

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County

Balto

Village or City

Essex md

Registration Dist. No.

44

No.

26 Woodrow Ave

St.

Ward

Length of residence in city or town where death occurred

yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

mos.

How long in U.S. if of foreign birth?

yrs.

mos.

ds.

## 2. FULL NAME

Minnie Alte

(a) Residence: No.

3219 Esther Place

Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

Female

## 4. COLOR OR RACE

White

## 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

married

## 5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

Richard Alte

## 6. DATE OF BIRTH (month, day, and year)

Apr 14 - 1881

## 7. AGE

Years

64

Months

8

Days

22

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

## OCCUPATION

## 8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Home

## 9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

## 10. Date deceased last worked at this occupation (month and year)

## 11. Total time (years) spent in this occupation

## 12. BIRTHPLACE (city or town) (State or country)

Balto

## FATHER

## 13. NAME

Edward Nelson

## 14. BIRTHPLACE (city or town) (State or country)

Balto

## MOTHER

## 15. MAIDEN NAME

Not known

## 16. BIRTHPLACE (city or town) (State or country)

## 17. INFORMANT (Address)

Mr Richard Alte  
3219 Esther Place

## 18. BURIAL, CREMATION, OR REMOVAL

Place

Oak Lawn Date Jan 9, 1946

## 19. UNDERTAKER (Address)

Joseph Stern & Son  
3001 Kentucky Ave

## 20. FILED

Jan 8, 1946

John J. Connelly, Jr.  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

January

(Month)

6

(Day)

1946

(Year)

## 22. I HEREBY CERTIFY, That I attended deceased from

Jan 1946 to Jan 5, 1946

I last saw him alive on Jan 4, 1946; death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were, as follows:

Arteriosclerosis  
Hypertension

Date of onset

1944

1944

## Other Contributory Causes of importance

Diabetes Mellitus  
Nephritis

1944

Jan 1944

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

## 23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

## 24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

James F. Karasick, M.D.  
3328 W. Redwood St.

M. D.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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## Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 00163 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 MoHospital, institution, or street address where death occurred:  
Hood Nursing Home 5501 Edmondson Ave.How long in hospital or institution? 6 Mo

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. St. James Apts Charles & Centre Sts.  
(If rural, give LOCATION) ✓

2. (a) If veteran, name war

## 3. (a) FULL NAME

Sybil Magale Archer

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Stevenson Archer

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 18648. AGE: Years 81 Months 4 Days 5 If less than one day  
..... hrs. .... min.9. Birthplace Texas  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name John Francis Magale13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs. Sybil SmithAddress 718 Homestead St. Balto. Md.17. Burial Date thereof Jan. 19, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Churchville, Md.Location Harford Co. Md.18. Funeral director Wm. J. Tiekner & Sons, Inc.Address North & Pa. Aves. Balto. Md.19. 1-17-46 19 46 Catholich  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 16, 1946 19 46 at 6:30 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31 19 45 to Jan 16 19 46and that I last saw him alive on Jan 15 19 46Immediate cause of death Chor Myocarditis

## DURATION

1 1/2Due to Arterio SclerosisCardio Vascular DiseaseDue to 3 1/2

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. H. H. M. D. or otherAddress 1-16 Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1700)

## CERTIFICATE OF DEATH

CC164

Reg. Dist. No. 35

## 1. PLACE OF DEATH

County BaltimoreCity or town Parkton P.O.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County BaltimoreCity or town Heard - Parkton P.O. R.F.D.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOSHUA WATSON ARMACOST

## 3. (b) Social Security Number

NONE

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Melvin Armacost

## 7. Birth date of deceased (mo., day, yr.)

Sept 9 - 1857

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

88412

hrs.

min.

## 9. Birthplace

Upper Meriden Ind  
(Town, county, and state)

## 10. Usual occupation

Retail Tanager

## 11. Industry or business

## FATHER

## 12. Name

Joshua Armacost

## 13. Birthplace

Unknown

## MOTHER

## 14. Maiden name

Elizabeth Brown

## 15. Birthplace

Unknown

## 16. Informant

Mrs. Grace Hollingshead

## Address

Parkton Ind

## 17. Burial

(Burial, cremation, or removal, which?)

## Date thereof

Jan 14 - 1946  
(month) (day) (year)

## Cemetery or crematory

St. Camel

## Location

Parkton, Ind

## 18. Funeral director

Howard J. Markline

## Address

White Hall Ind

## 19. Jan. 22, 1946

(Date rec'd by registrar)

19 46

Mrs. Howard Markline  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 19 46 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 17 19 46, to Jan 21 19 46  
and that I last saw him alive on Jan 21 19 46Immediate cause of death Myocardial Infarction

## DURATION

2 daysDue to Being Struck by Auto Jan 17, 46

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter Portner M.D.

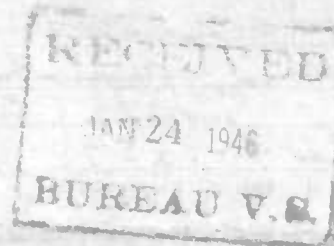
M. D. or other

Address White Hall Ind Date signed Jan 22, 46



Dr. Portner states that because of the deceased's age, the accident did have some bearing on his death. It would not have for a younger man. He had no broken bones and no internal injuries but had to remain in one position because of the accident.

by T. Nicklas - 8-2-46 (by phone)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1642

## CERTIFICATE OF DEATH

00165

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Balto.City or town Edgemere  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7409 Roberts Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto.City or town Edgemere  
(If outside city or town limits, write RURAL and give nearest town)Street No. 7409 Roberts Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3.(a) FULL NAME

ELMER BATES ASHER.

## 3.(b) Social Security Number

213-07-0679

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

Alice (Holstrom)

6.(c) If alive, give age.....years

7. Birth date of

deceased (mo., day, yr.)

Nov 11 - 1897

8. AGE:

Year

Months

Days

If less than one day

48

hrs.

min.

9. Birthplace

Aberdeen Md.

(Town, county, and state)

10. Usual occupation

Electrician

11. Industry or business

Beth Steel

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Alice Asher

Address

7409 Roberts Ave.

17.

(Burial, cremation, or removal. Which?)

Date thereof

11/31/46  
(month) (day) (year)

Cemetery or crematory

Balt. National Cem.

Location

Frederick Rd.

18. Funeral director

Philip I. Herwig & Sons

Address

2024 Orleans

19.

(Date rec'd by registrar)

1/28/46John J. Connelly

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

JAN. 28.46at 6:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....  
and that I last saw h.....live on.....19.....

Immediate cause of death

SHOT GUN WOUND THE  
RE. TEMPORAL REGION

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 1/28/46

Where did injury occur?

SP. PT. - 19 - BALTO - MD -  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Home

Means of injury

Shot by Shot GunInjured at work? NO

23. SIGNATURE

M. B. Davis, M.D.  
Asst. Dir. Md. Dep. of Health

Address

Baltimore, Md.Date signed 1/28/46

RECEIVED  
FEB 2 1946  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

## CERTIFICATE OF DEATH

00166 44  
Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Baltimore  
City or town Jones Creek  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County .....

City or town Jones Creek  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7316 Seise Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

### 3. (a) FULL NAME

Thomas Baker

### 3. (b) Social Security Number

#### 4. Sex

Male

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife .....

7. Birth date of deceased (mo., day, yr.) January 23<sup>rd</sup> 1946  
6. (c) If alive, give age ..... years

8. AGE: Years Months Days If less than one day  
1 hrs. min.

9. Birthplace Jones Creek  
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

12. Name Robert Baker

13. Birthplace Grant, Virginia

14. Maiden name Leoda M. Mosley

15. Birthplace Pulaski, Va.

16. Informant Mr Robert Baker

Address 7316 Seise Ave

17. Burial Date thereof 1/26/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glen Haven

Location Glen Burnie, Md.

18. Funeral director John F Henry Inc

Address 745 Light St.

19. Jan 25 1946 D. J. Farber  
(Data rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 24<sup>th</sup> 1946 at 10<sup>30</sup> P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 23 1946 to January 24 1946  
and that I last saw him/her alive on Jan 24 1946

Immediate cause of death Congenital Heart Dis.  
DURATION 2 days

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work?

23. SIGNATURE [Signature] M. D. or other

Address 520 D St S.W. Date signed SP77

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

RECEIVED

RECEIVED  
JAN 29 1946  
BUREAU V. #1



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change in age is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bd*

00167

FILM No. **I 04** MAY 28 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. **38**

### 1. PLACE OF DEATH:

County **Baltimore**

City or town **Catonsville 28**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **1 yr. 7mo. 26 days**

Hospital, institution, or street address where death occurred:

**Spring Grove State Hospital**

How long in hospital or institution? **1 yr. 7 mo. 26 days**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Prince Georges**

City or town **Mitchellville**  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

**B. FRANK BALL**

### 3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

**Male White Single**

6.(b) Name of husband or wife \_\_\_\_\_

8.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) **March 1, 1891**

8. AGE: Years Months Days If less than one day  
**54 55 2 19** hrs. min.

9. Birthplace **Aquasco, Maryland**  
(Town, county, and state)

10. Usual occupation **Farmer**

11. Industry or business **Agriculture**

12. Name **Sam Ball**

13. Birthplace **Maryland**

14. Maiden name **Lizzie Albey**

15. Birthplace **Maryland**

16. Informant **Hospital Records**

Address **Catonsville 28, Md.**

17. **Burial** Date thereof **1/24/46**  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematorium **St. John's**

Location **Collington Mt.**

18. Funeral director **Francis G. Gosh, Sons**

Address **Catonsville, Md.**

19. **1-22-46**  
(Date rec'd by registrar)

**Harry J. Muller**  
Deputy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH **January 20, 1946** at **5:15 P**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **May 25, 1944** to **January 20, 1946**

and that I last saw him alive on **January 20, 1946**

Immediate cause of death **Chronic myocarditis with acute exacerbation** DURATION **20 days**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **Pulmonary oedema** **1 hr.**

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE **Myrick W. Cullen, Jr.** M. D. or other \_\_\_\_\_

Address **Catonsville 28, Md.** Date signed **1/20/46**

Prince Georges

RECEIVED

JAN 23 1946

BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

00168

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.How long in hospital or institution? 80 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1503 Tempen Alley, Balto. Md.

(If rural, give LOCATION)

2(a) If veteran, name war WW #1

## 3. (a) FULL NAME

GEORGE A. BARNES (Bond)

## 3. (b) Social Security Number

4. Sex Male 5. Color or race negro 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife deceased

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 18868. AGE: Years 59 Months 5 Days 2 If less than one day  
.....hre. ....min.9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Charles Barnes13. Birthplace Baltimore, Md.14. Maiden name Suran Johnson15. Birthplace Baltimore, Md.16. Informant Clinical Records, Vets. Adm.Address Fort Howard, Md.17. BURIAL Date thereof 1-9-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BALTO., NATIONAL CEMETERY.Location FREDRICK RD. BALTO.18. Funeral director WILLIAM A. JACKSONAddress 916 Penna., Ave.19. 1-7 19 46 AW Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 19 46 at 8:03 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 17, 19 45 to Jan. 5 19 46and that I last saw him alive on January 5, 19 46

Immediate cause of death

Carcinoma of rectum with general-  
ized metastasesDURATION  
6 mos.  
plus

Due to

Due to

Other conditions Anemia, secondary; Heart  
Disease - coronary arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

Signature AW Hedrick A. M. BALTER, LT. COL. M. C. CLINICAL DIR.  
M. D. or other

VETS. ADM.

Address Fort Howard, Md. Date signed 1-5-46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00169

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
 Baltimore  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 222 days  
 Hospital, institution, or street address where death occurred:  
 Vets. Administration, Ft. Howard, Md.  
 How long in hospital or institution? 222 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland  
 County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 843 W. Fairmount Ave.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name War. WW & WW-2

## 3. (a) FULL NAME

LUTHER BARNES

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married but sep  
 6. (b) Name of husband or wife. Agnes Barnes  
 6. (c) If alive, give age 37 years  
 7. Birth date of deceased (mo., day, yr.) December 25, 1897  
 8. AGE: Years 48 Months 0 Days 20 If less than one day ..... hrs. .... min.

9. Birthplace Maryland (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business  
 12. Name John Barnes  
 13. Birthplace Maryland  
 14. Maiden name Annie Plate  
 15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm.  
 Address Fort Howard, Md.  
 17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-19-46 (month) (day) (year)  
 Cemetery or crematory Baltimore National Cemetery  
 Location 5501 Frederick Av. Balto. Md.  
 18. Funeral director Charles R. Law  
 Address 802 Madison Ave. Balto. Md.  
 19. 1-16 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1946 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945 to Jan. 15 1946 and that I last saw him alive on January 15 1946

Immediate cause of death Amyotrophic Lateral Sclerosis  
 DURATION 2 1/2 yrs. Approx.

Due to  
 Due to  
 Other conditions

(Include pregnancy within 3 months of death)  
 Major findings of operations None  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE A.M. BALTER, LT. COL. M.C. CLIN. DIR. M. D. or other  
 Address Fort Howard, Md. Date signed 1-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (820)

## CERTIFICATE OF DEATH

00170

Reg. Dist. No. 194

## 1. PLACE OF DEATH:

County Baltimore Dyers Yellin RoadCity or town Baltimore Cannonsburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 Days

Hospital, institution, or street address where death occurred:

Catonsville Md

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CarrollCity or town Westminster  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5 Chase St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sarah Matilda Barnes

## 3. (b) Social Security Number

4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Levi Barnes6. (c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) July 1 - 18708. AGE: Years 75 Months 6 Days 15 hrs. min.9. Birthplace Gettysburg Pa.  
(Town, county, and state)10. Usual occupation Home Wife

11. Industry or business

12. Name John Tristle13. Birthplace Gettysburg Pa14. Maiden name Elizabeth Deal15. Birthplace Gettysburg Pa16. Informant Levi BarnesAddress Westminster Md17. Buried Date thereof Jan 19 - 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Meadowbranch CwLocation Westminster Md18. Funeral director Bankard & SonsAddress East Main St Westminster Md19. Jan 17 19 46 John B. Longman  
(Date rec'd by registrar) (year) (month) (day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 19 46 at 12 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 19 46 to Jan 16 19 46 and that I last saw him alive on Jan 15 19 45Immediate cause of death Cerebral hemorrhageDue to Cerebral hemorrhageDue to Cerebral hemorrhage

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John B. Longman M. D. or otherAddress Ellicott City Md Date signed 1/16/46



DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JAN 30 1946

BUREAU V. B.

193

DEATH

202

6 (1) 10

Birth date of  
deceased (mo.)

A.E.

tribe...

si occupat

at pu

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00171

Reg. Dist. No.

## 1. PLACE OF DEATH

County... *Baltimore Co. Md.*City or town... *Towson Md.*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Md.* County... *Baltimore*City or town... *Towson*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *409 Fiamant Dr*  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) NAME

4. Sex... *Female* 5. Color or race... *Colored* 6. (a) Single, married, widowed, or divorced... *Divorced*

8. (b) Name of husband or wife

7. Birth... of... *April 19<sup>th</sup> 1897*  
(mo., day, yr.)8. AGE. Years... *48* Months... Days... If less than one day... hrs... min.9. Birthplace... *Hartford Co. Md.*  
(Town, county, and state)10. Usual occupation... *Housewife*

11. Industry or business

12. Name... *John F. Fletcher*13. Birthplace... *Hartford Co. Md.*14. Maiden name... *Georgiana Cox*15. Birthplace... *Hartford Co. Md.*16. Informant... *Agnie Johnson*Address... *2017 Mc Culloch St.*17. Date thereof... *1-19-46*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... *Pleasant Rest Cemetery*Location... *Towson Md.*18. Funeral director... *Archibald G. Gaddis*Address... *2101 Mc Culloch St. Baltimore*19. Jan. 19 *46* A. W. Hedrick  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH... *Jan. 17<sup>th</sup> 1946* at... *1946* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from... *Jan 3<sup>rd</sup> 1946* to... *Jan 17<sup>th</sup> 1946*  
and that I last saw him alive on... *Jan 15<sup>th</sup> 1946*

Immediate cause of death

DURATION

*Cerebral Hemorrhage (left)* *Feb 1945*Due to... *Excessively high blood pressure**Renal Artery Sclerosis*Due to... *Hypertension**Chronic Interstitial Nephritis*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... *Daniel J. W. Thompson* M. D. or other

Address... Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

00172

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Jan 19

(Date rec'd by registrar)

1946

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw him/her alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED  
FEB 3 1946  
BUREAU V.E.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00173

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Baltimore

City or town Edgemere  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Edgemere  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3019 Wells Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Anna Bartol

### 3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widow

6.(b) Name of husband or wife

Frank Bartol

7. Birth date of deceased (mo., day, yr.)

Feb. 15, 1867

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

78

11

2

hrs.

min.

9. Birthplace

Yugoslavia  
(town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Mrs. Geneva Horton

Address

7101 North Point Road

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Jan. 18, 1946  
(month) (day) (year)

Cemetery or crematory

Location

Johnstown, Penna.

18. Funeral director

John F. Denny, Inc.

Address

715 Light St.

19.

(Date rec'd by registrar)

19 46

Dorothy T. Harber

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 19 46 at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 19 46 to Jan 18 19 46

and that I last saw him alive on Jan 17 19 46

Immediate cause of death

Influenza

DURATION

14 days

Due to

Due to

Other conditions

Acute Bursosclerotic H+

disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. L. Denny, M.D.

Address

520 D St. Sp R 19 Md. 1/18/46

Date signed

MARGIN RESERVED FOR BINDING

VS-A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JAN 23 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

00174

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Balt  
 City or town Halethorpe  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4117 Old Marsh Rd  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Balt  
 City or town Halethorpe  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4117 Old Marsh Rd  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Walter J Beach

## 3. (b) Social Security Number

212-051230

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elizabeth Beach6. (c) If alive, give age 61 years7. Birth date of deceased (mo., day, yr.) Nov. 26 1876

8. AGE: Years 69 Months 1 Days 5 If less than one day  
 hrs. min.

9. Birthplace Balt Md  
(Town, county, and state)10. Usual occupation Chem11. Industry or business Quincy Distilling12. Name W J Beach13. Birthplace Balt Md14. Maiden name Anna Burger15. Birthplace Balt Md16. Informant Elizabeth J BeachAddress 4117 Old Marsh Rd17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan 4 1946  
(month) (day) (year)Cemetery or crematory CrownwoodLocation Balt Co. Md18. Funeral director Robert J. LittleAddress 2700 Edmondson Ave19. 1/3 19 46 AW Tednich  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 19 46 1-15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

DURATION

Coronary occlusion

Due to

Due to

Other conditions Sudden death  
Angina

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. W. Kieffer Edmondson  
M. D. or otherAddress 1010 Leiden Ave Date signed 1-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00175

Reg. Dist. No.

## 1. PLACE OF DEATH:

County BaltimoreCity or town Glen Arm  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Glen Arm  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Agnes Bensch

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female

white

Married

8.(b) Name of husband or wife Adolph7. Birth date of deceased (mo., day, yr.) April 28 1870

8.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years Months Days If less than one day  
75 8 20 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Port Huron Mich.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name David Sims13. Birthplace Canada14. Maiden name Amelia Hitchins15. Birthplace U.S.A.16. Informant Mr. Adolph BenschAddress Glen Arm Md.17. Removal Date thereof 1/13/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hinsdale, Illinois

Location \_\_\_\_\_

18. Funeral director William J. Tickner & SonsAddress North & Pennsylvania Aves19. 1/13 19 46 City Harroth Reg't  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1946 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 28 1945 to Jan. 12 1946  
and that I last saw him alive on Jan. 11 1945

Immediate cause of death

DURATION

Influenza 2 wks

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Clifford E. Hudson M.D. M. D. or otherAddress York Md. Date signed 1/12/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BFA*

00176

## CERTIFICATE OF DEATH

Reg. Dist. No. *41*

### 1. PLACE OF DEATH:

County *Baltimore*  
City or town *Dundalk*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Baltimore*  
City or town *Dundalk, Maryland*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *6911 Railway Avenue*  
(If rural, give LOCATION)

2. (a) If veteran, name war *ps*

### 3. (a) FULL NAME

*Louise Benson*

### 3. (b) Social Security Number

*None*

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

*Female White Married*

6. (b) Name of husband or wife *Leroy*

7. Birth date of deceased (mo., day, yr.) *Sept 1, 1887* 8. (c) If alive, give age *53* years

8. AGE: Years *58* Months *4* Days *1* If less than one day  
..... hrs. .... min.

9. Birthplace *Lethia Virginia*  
(Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business

FATHER 12. Name *Woodrow Wells*

13. Birthplace *Loanake Virginia*

MOTHER 14. Maiden name *?*

15. Birthplace *?*

18. Informant *Leroy Benson*

Address *6911 Railway Ave. Dundalk.*

19. *Removed* Date thereof *11/1/46*  
(Burial, cremation, or removal - Which?) (month) (day) (year)

Cemetery or crematory *Harwin*

Location *Roanoke Va.*

18. Funeral director *William Cook Inc*

Address *1217 1/2 Paul St.*

19. *1-4-* *46* *AW Hedrick*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *January 2* 19 *46* *12 Noon*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
..... 19....., to..... 19.....  
and that I last saw h..... alive on..... 19.....

Immediate cause of death *A-S-C-V-Renal Disease*

Due to *Coronary Occlusion*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury *?* Injured at work?

23. SIGNATURE *AW Hedrick*

Address *West N. Charles St. Baltimore - Md.* Date signed *1/1/46*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

00177

## CERTIFICATE OF DEATH

Reg. Dist. No. 34

## 1. PLACE OF DEATH

County BaltimoreCity or town Upper Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Upper Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Maggie C. BeutzSex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife James B Beutz7. Birth date of deceased (mo., day, yr.) Oct 24 - 1858 6.(c) If alive, give age 46 years8. AGE: Years 87 Months 3 Days 6 If less than one day hrs. min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation None

## 11. Industry or business

12. Name Regin H Annacost13. Birthplace Md14. Maiden name Mary C Cullison15. Birthplace Md16. Informant Wm. W BeutzAddress Upper Md17. Burial Date thereof Feb 1 - 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GraceLocation Balto Co18. Funeral director Edw C TiptonAddress Hampstead Md19. Jan 31 1946 Edw C Tipton Registrar  
(Date rec'd by registrar)

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1946 at 4:00 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 45 to Jan 30 1946and that I last saw ex alive on Sept 29 1946Immediate cause of death Arterio-sclerotic curvilinear  
vascular disease

## DURATION

10 years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice C. Porterfield M. D. or otherAddress Hampstead Md Date signed 1-30-46



RECEIVED

FEB 5 1946

BUREAU T S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00178

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 0 yrs., 5 mos., 0 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution? 0 yrs., 5 mos., 0 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 16 S. Collington Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John J. Bogdan

## 3. (b) Social Security Number

220-07-1075

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
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6. (b) Name of husband or wife Theresa Bogdan  
 6. (c) If alive, give age 47 years

7. Birth data of deceased (mo., day, yr.) March 18, 1895

8. AGE: Years <u>50</u>	Months <u>9</u>	Days <u>29</u>	If less than one day .....hrs. ....min.
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9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Painter  
 11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Peter Bogdan  
 13. Birthplace Poland  
 14. Maiden name Rose Augytyn  
 15. Birthplace Poland

16. Informant John J. Bogdan  
 Address 16 S. Collington Ave., Balto. Md.

17. Burial Date thereof Mon. 1/21/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Baltimore National Cemetery  
 Location Baltimore, Maryland  
 18. Funeral director M.F. Sadowski & Son  
 Address 1808 Eastern Ave., Balto., Md.

19. Jan. 16, 1946 Earl T. Webster  
 (Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 16, 1946 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16, 1945 to Jan. 16, 1946  
 and that I last saw him alive on January 16, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 5 Yrs.

Due to Tubercle Bacilli

Due to \_\_\_\_\_

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations No operation

Date of op. \_\_\_\_\_

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stewart S. Shaffer, M.D.

M.D. or other

Address Mount Wilson, Md. Date signed 1/16/46

Rec'd - 1-18-46 In E.E. Nichol

RECEIVED

JAN 19 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 312

## CERTIFICATE OF DEATH

00179

Reg. Dist. No. 97

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 months  
 Hospital, institution, or street address where death occurred:  
Masonic Home, Cockeysville Md  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll  
 City or town Port Deposit Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Miss Florence Bond

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 23 - 1871  
 8. AGE: Years 74 Months 8 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Port Deposit Md  
 (Town, county, and state)  
 10. Usual occupation None  
 11. Industry or business \_\_\_\_\_

FATHER 12. Name Thomas C Bond  
 13. Birthplace Baltimore Md  
 MOTHER 14. Maiden name Martha Virginia Anderson  
 15. Birthplace Port Deposit, Md  
 16. Informant Laura M. Schwoedes  
 Address Masonic Home Cockeysville  
 17. Burial Date thereof Jan 18 - 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory West Nottingham  
 Location Cecil Co  
 18. Funeral director Lee A. Patterson & Son  
 Address Curryville  
 19. 1/14/46 19 46 F.M. Schwoedes  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 19 46 at 12:40 pm  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 45 19 45 to Jan 13 19 46  
 and that I last saw him alive on Jan 13 19 46  
 Immediate cause of death Uremia  
 Due to Chronic Nephritis  
Intestinal  
 Due to Generalized Arterio Sclerosis  
 Other conditions \_\_\_\_\_

## DURATION

2 days

3 yrs

5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Wilbur F. Skillman Md M. D. or other  
66 Biddle St Address \_\_\_\_\_ Date signed 1/13/46

RECEIVED  
JAN 16 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16420

00180

4

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: *Baltimore*  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *3 yrs*  
 Hospital, institution, or street address where death occurred:  
*none*  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....*md.* County.....*Balto*  
 City or town.....*Burton*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....*Bellona Ct*  
 (If rural, give LOCATION)  
 2(a) If veteran, name war.....*(none)*

3. (a) FULL NAME  
*Frederic Nelson Bowditch.*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Single*  
 8. AGE: Years *17* Months *2* Days *29* If less than one day.....hrs.....min.  
 6. (c) If alive, give age.....years

8. (b) Name of husband or wife.....*none*  
 7. Birth date of deceased (mo., day, yr.) *October 30-1928*

9. Birthplace.....*Hagerstown Md*  
 (Town, county, and state)

10. Usual occupation.....*School-boy - (Stevens)*

11. Industry or business.....

FATHER 12. Name.....*Dr. Henry D. Bowditch*

13. Birthplace.....*Haverhill Conn*

MOTHER 14. Maiden name.....*Ruth Dillin*

15. Birthplace.....*Rodman N. Y.*

16. Informant.....*Dr. H. Bowditch (father)*

Address.....*Burton Md.*

17. *Burial* (Burial, cremation, or removal, which?) Date thereof.....*1-30-46*  
 (month) (day) (year)

Cemetery or crematory.....*Gruid Ridge*

Location.....*Lippsville Md.*

18. Funeral director.....*Shaw-Walker*

Address.....*108 W. Main Ave.*

19. *1/29* 19 *46*  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH.....*Jan 4 1946* at *9:00 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....19.....to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....*Suicide*

DURATION.....*50 days*

Due to.....*Bullet thru heart*

from.....*12 Calibre Rifle*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....*Suicide* Date of.....*1/28/46*

Where did injury occur?.....*Ruxton Md.*

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?

23. SIGNATURE.....*John S. Green Jr.*

M.D. or other.....

Address.....*Lansdowne - 4 - MD* Date signed.....*1/28/46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17423

## CERTIFICATE OF DEATH

00181

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Baltimore CountyCity or town Catonville - Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Fredrick Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey County BayonneCity or town Bayonne  
(If outside city or town limits, write RURAL and give nearest town)Street No. 131 W. 91st St

(If rural, give LOCATION)

2.(a) If veteran, name war World War II ✓

## 3. (a) FULL NAME.

David Davidson Boyd

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Divorced

## 6. (b) Name of husband or wife

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb - 6 - 1910

## 8. AGE:

35

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

New Jersey  
(Town, county, and state)

## 10. Usual occupation

(Discharged War Veteran)

## 11. Industry or business

unemployed

## 12. Name

David Boyd

## 13. Birthplace

Ireland

## 14. Maiden name

Agnes Davidson

## 15. Birthplace

Scotland

## 16. Informant

David Boyd

## 17. Burial

131 W. 91st St - Bayonne, N.J.

## 18. Cemetery or crematory

Calvary Cemetery

## 19. Location

Staten Island - N.Y.

## 20. Funeral director

Edw. J. Macnab

## 21. Address

Fredrick Road, P.O. Catonsville - Md.

## 22. Date rec'd by registrar

1-28-46

## 23. Date signed

1-28-46

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Jan 21 19 46 at home

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

## Immediate cause of death

Struck by train

## Due to

falling

## Due to

Badly managed

## Other conditions

Crushed skull

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Jan 21 - 46Where did injury occur? Catonsville, Baltimore (City or town) (County) (State)Injured at home, farm, industry, public place (where)? Public highwayMeans of injury struck by electric car Injured at work? no

## 23. SIGNATURE

Dr. M. D. or otherAddress 1000 Lehigh Date signed 1-28-46

CERTIFICATE OF DEATH

RECEIVED  
JAN 24 1946  
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-5

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, MarylandHow long in hospital or institution? 9 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2104 Herbert Street

(If rural, give LOCATION)

2. (a) If veteran, name war WW-I

## 3. (a) FULL NAME

DAVID BRICE

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Emma Brice

6. (c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.)

4-16-85

## 8. AGE:

Years

Months

Days

If less than one day

60911

hrs.

min.

## 9. Birthplace

Maryland

(Town, county, and state)

## 10. Usual occupation

Unemployed

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

David Brice

## 13. Birthplace

Maryland

## 14. Maiden name

Susan Connolly

## 15. Birthplace

Maryland

## 16. Informant

Clinical Records, Vets. Adm. Hosp.

## Address

Fort Howard, Maryland

## 17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb 1st 1946  
(month) (day) (year)

## Cemetery or crematory

Baltimore National Cemetery

## Location

Baltimore, Maryland

## 18. Funeral director

Wm. Cook

## Address

St. Paul & Preston, Balto., Md.

## 19.

1-30

(Date rec'd by registrar)

19 46aw Hedrich  
add

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1946 at 11:20P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19, 1946 to January 28, 1946and that I last saw him alive on January 28, 1946

## Immediate cause of death

Tuberculosis, chr. pul. far adv.  
active

## DURATION

3 Yrs.  
plus.

## Due to

## Due to

## Other conditions

Arthritis chr., Cervical  
spine  
(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

A. M. BALTER, LT. COL., M.D. or other IN. DIR.Address Fort Howard, Maryland Date signed 1-29-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## I. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 4 years, 6 months, 15 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution?..... 4 years, 6 months, 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 216 S. Collington Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... NO ✓

## 3. (a) FULL NAME

Catherine Brocky

## 3. (b) Social Security Number

(Brocky)

4. Sex..... female  
 5. Color or race..... white  
 6. (a) Single, married, widowed, or divorced..... widowed  
 6. (b) Name of husband or wife..... Michael Brocky  
 8. (c) If alive, give age..... - years  
 7. Birth date of deceased (mo., day, yr.)..... July 1950  
 8. AGE: Years..... 95 Months..... 6 Days..... If less than one day..... hrs. .... min.

9. Birthplace..... Poland  
 (Town, county, and state)  
 10. Usual occupation..... housewife  
 11. Industry or business..... home  
 12. Name..... ?  
 13. Birthplace..... Poland  
 14. Maiden name..... Catherine ?  
 15. Birthplace..... Poland

16. Informant..... Hospital Records  
 Address..... Baltimore 28, Md. (Catonsville)

17. Burial..... Buried Date thereof..... 1-26-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... St. Stanislaus  
 Location..... Balto City 24

18. Funeral director..... George A. Weber  
 Address..... 705 S. Ann St.

19. 1-25 19 46 W. H. H. H. Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 23 19 46 at 11:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 8 19 41 to January 23 19 46  
 and that I last saw her alive on January 23 19 46

Immediate cause of death..... Terminal Pneumonia DURATION..... 48 hours

Due to..... Chronic Myocardial Insufficiency Indef.

Due to..... Arteriosclerotic Cardiovascular Indef. Disease.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... Isadore Tuerk M. D. or other

Address..... Catonsville - 28, Md. Date signed..... 1/24/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 578

00184

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County... Baltimore,City or town... Catonsville,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Baltimore,City or town... Catonsville,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Edmondson Ridge Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Rev. J. McLain Brown

## 3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>
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6. (b) Name of husband or wife... L. Anna Tilghman6. (c) If alive, give age 82 years7. Birth date of deceased (mo., day, yr.) June 29, 1859

8. AGE: Years <u>86</u>	Months <u>6</u>	Days <u>10</u>	If less than one day .....hrs. ....min.
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9. Birthplace... Washington, D. C.  
(Town, county, and state)10. Usual occupation... Clergyman

## 11. Industry or business

12. Name... James R. Brown13. Birthplace... Wash. D. C.14. Maiden name... Rosina Bowen15. Birthplace... Philadelphia, Pa.18. Informant... Edward M. BrownAddress... 5609 York Road17. Burial Date thereof... 1/12/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Parsons Cemy.Location... Salisbury, Md.16. Funeral director... John A. Mitchell & SonsAddress... 1900 Eutaw Place19. Jan. 11 19 46 A. H. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan. 9, 19 46, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 4, 1945 19 45 to Jan. 9 19 46and that I last saw him alive on Jan. 8 19 46Immediate cause of death... Pulmonary edema  
Urinary obstruction

## DURATION

Due to... Carcinoma of prostate3 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John Z. Brown

M. D. or other

Address... 20 E. Preston St.Date signed... 1/10/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Bowyer



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00185

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 227 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, MarylandHow long in hospital or institution? 227 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester CountyCity or town Church Creek  
(If outside city or town limits, write RURAL and give nearest town)Street No. None  
(If rural, give LOCATION)2.(a) If veteran, name war WW-I

## 3. (a) FULL NAME

JAMES BRUMMETTE

## 3. (b) Social Security Number

214-07-7536

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife Mrs. Lillian A. Brummette6. (c) If alive, give age 57 years7. Birth date of deceased (mo., day, yr.) 12-6-81

8. AGE: Years Months Days If less than one day

64118

.....hrs. ....min.

9. Birthplace Walnut, Tenn.

(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name James Brummette13. Birthplace Tenn.14. Maiden name Ameda Bowers15. Birthplace Tenn.16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howgrd, Maryland17. Burial Date thereof Jan 27, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Old Trinity CemeteryLocation Church Creek, Md.18. Funeral director A. Lee OderAddress 4644 York Rd., Balto., Md.19. 1/27 19 46  
(Date rec'd by registrar) Registrar Milton M. Brummette

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 24, 1946 at 8:25 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11, 1945 to January 24, 1946and that I last saw him alive on January 24, 1946

Immediate cause of death

Squamous cell carcinoma of right antrum

DURATION

10 Mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. BalterA. M. BALTER, LT. COL., M.C. CLIN. DIR.Address Fort Howard, Maryland Date signed 1-24-46

RECEIVED

FEB. 8 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

00186

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Garrison, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore  
 City or town Garrison  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Reisterstown Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth Anderson Buell

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

John A. Buell

7. Birth date of

deceased (mo., day, yr.)

July 2, 1870

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

75612

hrs.

min.

9. Birthplace

Garrison, Balt. Co., Maryland  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Housewife

FATHER

12. Name

S. Merryman Anderson

13. Birthplace

Balt. Co., Md.

MOTHER

14. Maiden name

S. Buell, Bowley

15. Birthplace

Balt. Co., Md.

16. Informant

John A. Buell

Address

Reisterstown Rd Garrison Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

1-17-46  
(month) (day) (year)

Cemetery or crematory

David Ridge

Location

Pikesville, Maryland

18. Funeral director

Loring Byers

Address

5005 Park Heights Rd19. 1-14-

(Date rec'd by registrar)

19 46E E Nichols

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

1-14

19

46 at 7:20 P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Nov 22 1945 to Jan 14 1946

and that I last saw her alive on

Jan 13 1946

Immediate cause of death

Cardio-vascular

DURATION

2

Due to

Arterio Sclerosis

Due to

Other conditions

General arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E E Nichols Md

M. D. or other

Address

Pikesville MdDate signed 1-14-46

RECEIVED

JAN 16 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 0618744  
 ★ Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Balto. ....

City or town..... Sparrows Pt. ....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

422 E St.

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md ..... County..... Balto. ....

City or town..... Sparrows Pt. ....  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 422 E St. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

GEORGE BURGESS

## 3. (b) Social Security Number

213-07-6297

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife..... Ellen A. Burgess

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.) September 23, 1888

8. AGE:

Years 57

Months 4

Days 0

If less than one day

..... hrs. .... min.

9. Birthplace..... England

(Town, county, and state)

10. Usual occupation..... Maintenance Mechanic

11. Industry or business..... Bethlehem Steel Co.

FATHER  
MOTHER

12. Name..... William Burgess

13. Birthplace..... England

14. Maiden name..... Mary E. Wilkinson

15. Birthplace..... England

16. Informant..... Mrs. Ellen A. Burgess

Address..... 422 E St., Sparrows Pt., Md.

17. Burial..... Date thereof..... 1/26/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Oaklawn Cem.

Location..... Balto., Md.

18. Funeral director..... WM. J. TICKNER &amp; SONS

Address..... Balto., Md.

19. Jan 25 - 46  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 23, ..... 19.. 46, at..... 5:30 PM A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1944 to Jan 23, 1946  
and that I last saw him alive on Jan 2/2 and 1946

Immediate cause of death

Cerebral hemorrhage

DURATION

3 days

Due to

Hypertensive Cardiovascular Disease

2 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

Dawson L. Harbers

M. D. or other

Address..... Sparrows Pt. 19 Md. Date signed..... 1/25/46

RECEIVED

JAN 28 1946

BUREAU VS



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-9

00188

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County Balto.City or town Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Karl F. Burns

## 3.(b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Divorced

6.(b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.) Nov. 11, 1888

## 8. AGE:

Years

Months

Days

If less than one day

5728

hrs. min.

9. Birthplace Baltimore City

(Town, county, and state)

10. Usual occupation Retired Baltimore TransitCompany

## 11. Industry or business

## FATHER

12. Name Wm. F. Burns13. Birthplace Md.

## MOTHER

14. Maiden name Clara Grempler15. Birthplace Penna.16. Informant Mrs. Amelia C. PierceAddress Owings Mills, Md.17. Burial Date thereof Jan 23, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Louden ParkLocation Baltimore City18. Funeral director J.F. Eline & SonsAddress Reisterstown, Md.19. 1-22 1946 Marv B. Eline

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19- 1946, at M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 461-2- 1942 to 1-19- 1946and that I last saw him alive on 1-16-46 1946Immediate cause of death myocarditis, chronic

## DURATION

Due to hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE James G. Saffell M.D.

M. D. or other

Address Reisterstown Md. Date signed 1/21/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 23 1948  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00189

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Balto.City or town Relay  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1600 Linden Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Relay  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1600 Linden Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

THOMAS EDWARD BYERS

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife Mary E. Byers7. Birth date of deceased (mo., day, yr.) Dec. 30, 1866

6. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

79

0

1

hrs.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business

FATHER  
MOTHER12. Name James Frederick Byers13. Birthplace Liberty Town, Md.14. Maiden name Mary Ann Richard Byers15. Birthplace Woodenbury, Md.16. Informant Miss Rose Banks

Address

1600 Linden Ave., Relay17. Burial Date thereof 1/4/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Lorraine Cen.Location Woodlawn, Md.18. Funeral director WM. J. TICKNER & SONS

Address

Balto., Md.19. 1/3/46  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 19 46, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 30 to Jan 1 19 46and that I last saw him alive on Dec 30th 19 45Immediate cause of death Angina pectoris

DURATION

2 daysDue to Coronary Spasms5 yrs.Due to Arterio Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frederick Byers

M. D. or other

Address Mary Ann Byers, Balto. Date signed 1-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 834

## CERTIFICATE OF DEATH

00190

Reg. Dist. No. 82

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

14 Cedarwood Rd

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltCity or town Catonville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 14 Cedarwood Rd  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Anne Caton

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Michael J. Caton7. Birth date of deceased (mo., day, yr.) March 14, 1866

6.(c) If alive, give age years

8. AGE: Years 79 Months 10 Days 14 If less than one day  
.....hrs. ....min.9. Birthplace md  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Frank Connor13. Birthplace Ireland14. Maiden name Anne Gillen15. Birthplace Ireland16. Informant Miss Eileen E. CatonAddress 14 Cedarwood Rd17. Burial Date thereof Feb. 1, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CathedralLocation Baltimore18. Funeral director George R. FoleyAddress Fulton Ave. & Fayette St.19. 1-31- 1946 Harold Miller Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19, 1944 to Jan 28, 1946and that I last saw him alive on Jan 28, 1946Immediate cause of death Pulmonary edemaDue to hypertensionDue to hypertensionOther conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Cogan

M. D. or other

Address 14 Cedarwood Rd Date signed 1/30/46

RECEIVED

FEB 2 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

00191

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Edgemoor  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 years  
 Hospital, institution, or street address where death occurred:  
Lodge Farm Road Edgemoor  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Baltimore  
 City or town Edgemoor  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Lodge Farm Rd  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

William B. Cleary Jr

## 3. (b) Social Security Number

4. Sex Male 5. Color or race col. 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) October 4, 1850  
 8. AGE: Years 95 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

8. Birthplace Pa. (Town, county, and state)

10. Usual occupation farmer

11. Industry or business

FATHER 12. Name Unknown  
 13. Birthplace

MOTHER 14. Maiden name Unknown  
 15. Birthplace

16. Informant William B. Cleary Jr  
 Address 1600 E. Bridle St

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 5 / 46 (month) (day) (year)  
 Cemetery or crematory Mt. Calvary Cemetery  
 Location 99 County, Md.

18. Funeral director Mrs. Robert G. Ellis & Daughters  
 Address 1129 N. Caroline St

19. 1/4 46 A. W. Hedrick  
 (Date rec'd by registrar) (Year) (Name) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 2nd 1946 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20th 1945 to Jan 2nd 1946 and that I last saw him alive on Jan 2nd 1946

Immediate cause of death Pneumonia DURATION 13 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Cleary Jr M. D. or other

Address 107 N. Main St. Dundalk Md (City or town) (County) (State)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

00192

Reg. Diat. No. 23

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cuning Mills, Md. (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 yrs; 11 mos; 2 dgs  
 Hospital, institution, or street address where death occurred:  
Racwood  
 How long in hospital or institution? 17 yrs; 11 mos; 2 dgs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto.  
 City or town Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1100 DuKeland St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Emklin, Lena Sarah  
 4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced S.

## 3. (b) Social Security Number

none

## 6.(b) Name of husband or wife

6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 6 Jan 1921

8. AGE: Years Months Days If less than one day  
25 6 4 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore City  
 (Town, county, and state)

10. Usual occupation Domestic, Racwood State

11. Industry or business Daying School

12. Name Albert Jerome Emklin

13. Birthplace md.

14. Maiden name Estimide Steeper

15. Birthplace md.

16. Informant Intentional Records

Address Cuning Mills, Md.

17. Burial Date thereof Jan 14 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Sacred Heart

Location German Hill Road

18. Funeral director Libby & Zeller inc.

Address 403 D. Wolfe St.

19. Jan 11 44 A. Th. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Jan 1946 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 Jan 1946 to 10 Jan 1946 and that I last saw him alive on 10 Jan 1946

Immediate cause of death \_\_\_\_\_ DURATION

Broncho-Pneumonia 2 days

Due to Acute Bronchitis 5 "

Due to \_\_\_\_\_

Other conditions Little's Disease with  
symptomatic Grand mal Epilepsy Birth  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H. B. Butler, M.D. M. D. or other

Address Cuning Mills, Md. Date signed 10 Jan 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00194

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

## 1. PLACE OF DEATH

County BaltimoreCity or town Parkton RFD Ind  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 51 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County BaltimoreCity or town Parkton Ind  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

EDNA BLANCHE COOPER

## 3. (b) Social Security Number

NONE

## 4. Sex

Female

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

single

## 6.(b) Name of husband or wife

6.(c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

March 1 - 1894

## 8. AGE:

Years

Months

Days

If less than one day

511014

hrs.

min.

## 9. Birthplace

Parkton Ind

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER

## 12. Name

James Cooper

## 13. Birthplace

Fruitland Ind

MOTHER

## 14. Maiden name

Clara E. Amason

## 15. Birthplace

Parkton Ind

## 16. Informant

Harry C. Cooper

## Address

Parkton Ind

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan 18, 1946  
(month) (day) (year)

## Cemetery or crematory

Pine Grove

## Location

Parkton Ind

## 18. Funeral director

Harold S. Markline

## Address

White Hall Ind

## 19. Date rec'd by registrar

Jan 17, 1946Mar 2, 1946Harold S. Markline

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 - 1946 at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 15 - 1945 to Jan 15 - 1946and that I last saw him alive on Jan 15 - 1946

## Immediate cause of death

Malignant Carcinoma of Breast

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

James L. Gage

M. D. or other

Address New Freedom Pa Date signed 1/16-46

RECEIVED BY THE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

RECEIVED  
JAN 19 1946  
BUREAU V.B.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore County  
City or town Baltimore - 4101 West Drive  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Baltimore - 4101 West Drive  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4101 West Drive  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

IRA E COSS

### 3. (b) Social Security Number

218-16-9662

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Carolyn Diehl Coss 6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) October 30, 1883  
8. AGE: Years 62 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Time Keeper

11. Industry or business Belvedere Hotel

12. Name Albert G. Coss

13. Birthplace Baltimore, Maryland

14. Maiden name Elizabeth A. Hayes

15. Birthplace Baltimore, Maryland

16. Informant Carolyn Kueger

Address 3rd Avenue, Near Wilkins

17. Burial Date thereof 1/23/46  
(Burial, cremation, or removal of body) (month) (day) (year)

Cemetary or crematory Woodlawn Cemetery

Location Woodlawn Cemetery

18. Funeral director William Cook, Inc.

Address 1217 St. Paul Street

19. 1-22-46 19 46 Cuffed  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 20 JANUARY 1946 at 7:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JANUARY 17 1946 to JANUARY 20 1946

and that I last saw him alive on JANUARY 20 1946

Immediate cause of death CARDIAC FAILURE

Due to Uremia

Due to Chronic Nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edgar F. Williamson M.D.

Address 201 Helton Ave Catonsville, Md Date signed 1-21-46

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The facts are especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 958

## CERTIFICATE OF DEATH

00196

Reg. Dist. No. 44

## 1. PLACE OF DEATH

County 7310 Bay Front RoadCity or town Sparrows Point - Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Grace Crucher

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FemaleWhiteSingle

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

October 13 - 1897

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Date thereof

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

20. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 11. 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 29. 1945 to Jan. 11. 1946and that I last saw him alive on Jan. 11. 1946

Immediate cause of death

DURATION

Myocardial Failure. 3 weeks.

Due to

Rheumatic Carditis. 30 yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

Louis N. TollinAddress Sparrows Point, Md.Date signed Jan. 11. 46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

00197 32  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville, Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Pikesville, Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 20 Brightside av  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Edward M. Crusey Crusey

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Katie C. Crusey

7. Birth date of

deceased (mo., day, yr.)

April 21 - 1884

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

61830

hrs.

min.

9. Birthplace

Baltimore Co., Md  
(Town, county, and state)

10. Usual occupation

Electrician

11. Industry or business

FATHER

12. Name

Joseph Crusey

13. Birthplace

Lancaster Pa

14. Maiden name

Katherine Lambright

15. Birthplace

Lancaster Pa

16. Informant

Katie C. Crusey

Address

20 Brightside av. Pikesville

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 23 - 46  
(month) (day) (year)

Cemetery or crematory

David Ridge

Location

Pikesville, Maryland

18. Funeral director

Frank H. Spurd

Address

Pikesville, Maryland

19.

1 - 21 - 1946

(Date rec'd by registrar)

E. E. Nichols

-muv

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 20.19. 46, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 419. 43, to Jan 2019. 46and that I last saw him alive on Jan 20 19. 46

Immediate cause of death

Coronary Thrombosis

DURATION

4 days

Due to

Arterial Hypertension3 yrs

Due to

Arterio Sclerosis3 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

E. E. Nichols M.D. or other

Address

Pikesville MdDate signed 1-21-46



RECEIVED  
JAN 22 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

## CERTIFICATE OF DEATH

00198

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Baltimore CountyCity or town Back River Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs or more

Hospital, institution, or street address where death occurred:

Back River Neck Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Back River  
(If outside city or town limits, write RURAL and give nearest town)Street No. Back River Neck Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Moses Davenport

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Olivia7. Birth date of deceased (mo., day, yr.) Oct 4 1896

8.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

49 hrs. min.9. Birthplace No  
(Town, county, and state)10. Usual occupation Latimer

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Olivia DavenportAddress Back River Neck Road17. Burial Date thereof Jan 6/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Sharp St. CemeteryLocation Chase Md.18. Funeral director Mrs Robert G. Elliot & DgtAddress 1129 N. Caroline St.19. 14 46 A.W. Hedrich  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 19 46 at 11 34 PM

21. I CERTIFY (that death occurred on the date above stated; that I attended deceased from

Dec 13 19 45 to 19 45and that I last saw him alive on Dec 29 19 45Immediate cause of death Pulmonary Tuberculosis

DURATION

7

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Bernard Harris M.D.Address 1207 N. Caroline St. Date signed 1/3/46

M. D. or other

1207 N. Caroline St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00199

Reg. Dist. No. 34

1. PLACE OF DEATH:  
 County..... Baltimore  
 City or town..... Albany Town, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 27 months  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore  
 City or town..... Albany Town, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2. (If death in home)..... P.O. Hampstead Md R.F.D.

## 3. (a) FULL NAME

John White Davis

## 3. (b) Social Security Number

219-12-9760

4. Sex..... male 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... married  
 6. (b) Name of husband or wife..... Frances Bell Davis  
 6. (c) If alive, give age..... 51 years  
 7. Birth date of deceased (mo., day, yr.)..... March 21, 1876  
 8. AGE: Years..... 69 Months..... 9 Days..... 25 It less than one day..... hrs. .... mto.

9. Birthplace..... Newark New Jersey  
 (Town, county, and state)  
 10. Usual occupation..... Retired Salesman  
 11. Industry or business..... Machine Engine  
 12. Name..... James Davis  
 13. Birthplace..... unknown  
 14. Maiden name..... unknown  
 15. Birthplace..... unknown

16. Informant..... Mrs. Frances Bell Davis  
 Address..... Hampstead Md.  
 17. Burial..... Burial Date thereof..... Jan 18/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Grave Plot  
 Location..... Balto Co. Md.  
 18. Funeral director..... Edw. J. Tipton  
 Address..... Hampstead Md.  
 19. Jan 16 - 1946 (Date rec'd by registrar) Registrar..... Ernest E. Finkle

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 15 1946, at 10 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 1946 to January 15 1946 and that I last saw him alive on January 15 1946  
 Immediate cause of death..... Bilateral Lobar Pneumonia DURATION..... 5 days  
 Due to.....  
 Due to.....  
 Other conditions..... Chronic Myocarditis  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE..... Joseph E. Bush M.D. M. D. or other  
 Address..... Hampstead Md. Date signed 1-15-46

RECEIVED  
JAN 17 1946  
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

## CERTIFICATE OF DEATH

★00193 35-  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore  
City or town Rural near Freeland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 yrs. 6 mos.  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Rural near Freeland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. West of Freeland  
(If rural, give LOCATION)  
2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Charles Edward Dell

## 3. (b) Social Security Number

212-03-8233

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Esther Lenora  
6.(c) If alive, give age 50 years  
7. Birth date of deceased (mo., day, yr.) January 16, 1896  
8. AGE: Years 50 Months 7 Days 7 If less than one day  
.....hrs. ....min.

9. Birthplace Balta Co., Md.  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Plastic Mdlg. Plant

12. Name Nimrod Dell

13. Birthplace Md.

14. Maiden name Annie Fry

15. Birthplace Md.

16. Informant Mrs. Esther L. Dell

Address Freeland, Md.

17. Burial Date thereof Jan 26, 1946  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Mt Zion Cemetery

Location Freeland, Md.

18. Funeral director Joseph Hartung

Address New Freedom Pa

19. Jan 24 19 46 Charles E. Dell  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH January 23, 1946 at 1:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1943 to Jan 23 1946

and that I last saw him alive on Jan 22 1946

Immediate cause of death Mitral stenosis

DURATION

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

.....Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? .....

(City or town) (County) (State)

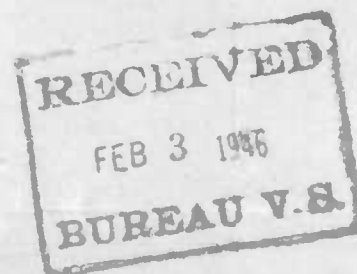
Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work?

23. SIGNATURE A. M. Francis M. D. or

Address Parlerton, Md Date signed 1/24/46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

## CERTIFICATE OF DEATH

00200

Reg. Diat. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Garrison  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

35 yrs.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Garrison  
(If outside city or town limits, write RURAL and give nearest town)Street No. Montrose Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mr. John Thomas Devese

## 3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Lizze Devese

7. Birth date of

deceased (mo., day, yr.)

Oct 18, 1869

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

76312-

hrs.

min.

9. Birthplace

Ecalster

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER  
MOTHER

12. Name

William Devese

13. Birthplace

Baltimore Co. Maryland

14. Maiden name

Elizabeth Gerhardt

15. Birthplace

Balts. Co. Maryland

16. Informant

Charles Devese

Address

Pikesville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

2/1/46

(month) (day) (year)

Cemetery or crematory

Druid Ridge

Location

Pikesville, Maryland

18. Funeral director

Frank H. Newell

Address

Pikesville, Maryland

19. V - 31 - 46

(Date rec'd by registrar)

Dr. E. E. Nichols  
me Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1946, at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him alive on Jan 28, 1946

Immediate cause of death

DURATION

Cancer of the larynx6 mos.

Due to

Due to

Other conditions

CachexiaAnemia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John Thomas Devese  
Pikesville, Md M. D. or other

Address

Date signed 1/30/46

RECEIVED  
FEB 2 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 982

## CERTIFICATE OF DEATH

Reg. Dist. No. 00201 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Sparrows Pt - Balto 19 -  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? 7 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto  
 City or town Sparrows Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3808 Nepp Ave  
 (If rural, give LOCATION)

2(a) If veteran, name war.....

## 3. (a) FULL NAME

Louisa V. Dickinson

## 3. (b) Social Security Number

4. Sex ♀ 5. Color or race W 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Harvey J. Dickinson  
 6. (c) If alive, give age 82 years  
 7. Birth date of deceased (mo., day, yr.) Sept 10 1865  
 8. AGE: Years 80 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore  
 (Town, county, and state)  
 10. Usual occupation At Home  
 11. Industry or business \_\_\_\_\_  
 12. Name Wm Preston  
 13. Birthplace Baltimore  
 14. Maiden name Don't know  
 15. Birthplace Baltimore

16. Informant Albert H. Hall  
 Address 3010 Salisbury Ave  
Balt Bk  
 17. (Burial, cremation, or removal Which?) Date thereof Jan 28  
 (month) (day) (year)  
 Cemetery or crematory Land on Park Comm  
 Location City  
 18. Funeral director Welrich Funeral Home  
 Address 2008 Orleans St  
 19. Jan 25 - 46 Dawson L. Harber  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1946 at 11:45 P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1946 to Jan 24 1946  
 and that I last saw him alive on Jan 20 1946  
 Immediate cause of death Influenza & Bronchitis  
 Due to Myocardial degeneration Unknown  
 Due to Arterio-sclerosis Unknown  
(General)  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

## DURATION

One week

## Major findings of operations.

## Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

Dawson L. Harber  
Sparrows Point - 19-MD  
 Address \_\_\_\_\_ M. D. or Chf. \_\_\_\_\_  
 Date signed 1/25/46

RECEIVED  
JAN 29 1946  
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

00202

## CERTIFICATE OF DEATH

★ Reg. Diat. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

820 E. Joppa RoadHow long in hospital or institution? none

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. 820 E. Joppa Road  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Clara Ida Didenhover

## 3. (b) Social Security Number

4. Sex <u>female</u>	5. Color or race <u>white</u>	6.(a) Single, married, widowed, or divorced <u>widowed</u>
-------------------------	----------------------------------	---

6.(b) Name of husband or wife Harry W. Didenhover

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 12, 1860

8. AGE:	Years	Months	Days	It less than one day
	<u>86</u>	<u>8</u>	<u>24</u>	..... hrs. .... min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation none

11. Industry or business .....

12. Name Thomas Godman13. Birthplace Baltimore, Md.14. Maiden name Emma Bell15. Birthplace Baltimore, Md.16. Informant William M. DidenhoverAddress 212 W. Chesapeake Ave., Towson, Md.17. Burial Date thereof 1/9/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mount OlivetLocation Baltimore, Md.18. Funeral director John O. Mitchell & Sons Inc.Address 1900 Eutaw Place, Balto.-17-Md.19. Jan 8 19 46 Registrar

Date rec'd by registrar .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 19 46 at 10 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 19 44 to Jan 6 19 46and that I last saw him alive on Jan 6 19 46

Immediate cause of death .....

Cancer (Lung)

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury .....

Injured at work?

23. SIGNATURE Thos. Godman M. D. or otherAddress Baltimore Date signed 1/10/46

RECEIVED  
FEB 3 1946  
BUREAU V 6



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00203

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County.....Baltimore

City or town.....Catonsville -  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 8 mos.

Hospital, institution, or street address where death occurred:

Posting Ave. Home in the Pines"

How long in hospital or institution? 2 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....Baltimore

City or town.....Catonsville -  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Emma Dietrich.

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife.....Mrs. W. Dietrich

7. Birth date of deceased (mo., day, yr.)

Sept. 9 - 1855.

8. AGE:

Years 90 Months 4 Days 3

9. Birthplace.....Baltimore - Md.

(Town, county, and state)

10. Usual occupation.....Housewife

11. Industry or business.....At home

12. Name.....John W. Dietrich

13. Birthplace.....Baltimore - Md.

14. Maiden name.....Unknown

15. Birthplace.....Germany

16. Informant.....Mr. Wm. H. Dietrich

Address 432 N. Nelson St. - Arlington Hk.

17. Burial, cremation, or removal, (Which?)

Date thereof Jan. 15 - 1946.

Cemetery or crematory.....Baltimore - Cemetery

Location.....Baltimore - Md.

18. Funeral director.....Charles J. Schwab

Address 505 N. Monroe St.

19. (Date registered by registrar)

1/14 46 J. W. Dietrich

Registral

## MEDICAL CERTIFICATION

20. DATE OF DEATH January - 12th 1946 at 7:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 23 1945 to Jan. 12 1946

and that I last saw him alive on January 12 1946

Immediate cause of death

Myocardial infarction

DURATION

3 mo.

Due to.....Scurvy of arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE.....Wilbur K. Gallagher M.D.

Address.....Catonsville - Md. Date signed.....1-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 126

## CERTIFICATE OF DEATH

00204

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Oct 18, 1945  
 Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Maryland

How long in hospital or institution? Since Oct 18, 1945

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City

City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 314 Elmo St  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Christina Duklowski Dublewski

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Stanley Duklowski

7. Birth date of deceased (mo., day, yr.) April 23, 1925 6. (c) If alive, give age 22 years

8. AGE: Years 20 Months 8 Days      If less than one day      hrs.      min.

9. Birthplace Baltimore Md  
 (Town, county and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Adam Richawicki

13. Birthplace Maryland

14. Maiden name Francis Stada

15. Birthplace Maryland

16. Informant Personal History- Hospital Records

Address Eudowood Sanatorium Towson 4, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof 1-8-46  
 (month) (day) (year)

Cemetery or crematory St Stanislaus

Location Baltimore Md

18. Funeral director George R. Weber

Address 205 So Ann St

19. 1-7-46 Dr. J. J. ...  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 5, 1946 at 9:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18, 1945 to Jan 5, 1946

and that I last saw him alive on January 4, 1946

Immediate cause of death Pulmonary tuberculosis

Other conditions     

Major findings of operations     

Antopsy results     

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide      Date of     

Where did injury occur?      (City or town)      (County)      (State)

Injured at home, farm, industry, public place (where?)     

Means of injury      Injured at work?     

23. SIGNATURE William A. Bridges M. D. or other     

Address Towson, Maryland Date signed 1-5-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County BradshawCity or town md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltimoreCity or town   
(If outside city or town limits, write RURAL and give nearest town)Street No.   
(If rural, give LOCATION)2.(a) If veteran, name war 

## 3. (a) FULL NAME

JAMES H ELLIOT.

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Mary Elliott

## 7. Birth date of deceased (mo., day, yr.)

1876

## 6. (c) If alive, give age years

## 8. AGE:

69

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

va

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

FATHER

## 12. Name

James Elliott

## 13. Birthplace

va

MOTHER

## 14. Maiden name

unknown

## 15. Birthplace

## 16. Informant

Winnie Elliott

## Address

Bradshaw md

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

Jan 5-46  
(month) (day) (year)

## Cemetery or crematory

Belton Cemetery

## Location

Upper Falls

## 18. Funeral director

David Anderson

## Address

Upper Falls md

## 19.

(Date rec'd by registrar)

19

Registrar

## 23. SIGNATURE

W. J. Geller M.D.

M. D. or other

## Address

Ridge Rd. Balt-6

Date signed

1/2/45

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1946, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 17 1945, to Oct 31 1945and that I last saw him alive on  19

Immediate cause of death

Coronary thrombosis

DURATION

Due to

Atherosclerotic heart2 yrs

Due to

12 years

Other conditions

myocardial infarction

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

RECEIVED

JAN 8 1946

BUREAU V.C.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County Baltimore Registration Dist. No. 41  
 Village or City Beneea Park, Waters No. Hawthorne Court Ward  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U.S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## 2. FULL NAME

Robert Gordon Elliott  
 (a) Residence: No. 800 E. 33rd St. St. \_\_\_\_\_ Ward. \_\_\_\_\_  
 (Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Single</u>		
6. DATE OF BIRTH (month, day, and year) <u>July 11/1923</u>		
7. AGE <u>22</u>	Years <u>11</u>	Months <u>1</u>
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.		9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>Dunbar H.O.A.</u>
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore City  
 (State or country)

13. NAME Thomas D. Elliott

14. BIRTHPLACE (city or town) Balto. Co.  
 (State or country) Parkton

15. MAIDEN NAME Ethel M. Northampton

16. BIRTHPLACE (city or town) Baltimore  
 (State or country)

17. INFORMANT Thomas D. Elliott (Father)  
 (Address) 2313 Maryland Ave. Balto.

18. BURIAL, CREMATION, OR REMOVAL  
 Place Beneea Park Date 7/5/46

19. UNOERTAKER Wm. Fickner  
 (Address) work + Res. are

20. FILED 7/4/46 8 M. C. armstrong  
 Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

Jan 10, 1946  
 (Month) (Day) (Year)

## 22. I HEREBY CERTIFY, That I attended deceased from

Jan 1946, to \_\_\_\_\_, 19\_\_\_\_

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Fracture neck  
Cervical vertebra

## Other Contributory Causes of Importance:

Found in water  
July 3/46

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

## 23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide Accident Date of injury 1/10, 1946

Where did injury occur? Hawthorne Court, Balto. Co.

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Public Place

Manner of Injury Fell in airplane

Nature of Injury Fractured vertebra

## 24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) Dr. Mearns M.D. M. D.

(Address) Dunbar H.O.A.

MARGIN RESERVED FOR BINDING

V.S. No. 1

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.



# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

*Arteriosclerosis*

Date of onset

*1915*

*Chronic interstitial nephritis*

*1921*

*Cerebral hemorrhage*

*July 5, 1927*

Other contributory causes of importance:

*Gallstones*

*May 1, 1923*

## Example II

The principal cause of death and related causes of importance were as follows:

Date of onset

*Attack of epilepsy*

*1 week ago*

*Run over by street car*

*1 week ago*

*Peritonitis*

*3 days ago*

Other contributory causes of importance:

*Gastroenteritis*

*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00208

Reg. Dist. No. 43

## 1. PLACE OF DEATH

County Baltimore  
 City or town Raspeburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 75 years  
 Hospital, institution, or street address where death occurred:  
No  
 How long in hospital or institution? No

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Raspeburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. No  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war No

## 3. (a) FULL NAME

Carrie S Ender

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married6. (b) Name of husband or wife Frederick Ender

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 18588. AGE: Years Months Days If less than one day  
87 1 13 hrs. min.9. Birthplace Germany  
(Town, county, and state)10. Usual occupation at home

11. Industry or business

12. Name - Solomon13. Birthplace Germany14. Maiden name Unknown15. Birthplace Germany16. Informant Frederick Ender  
Address Ridge Rd. Raspeburg17. Burial Date thereof Jan 8 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peters Luth. CemeteryLocation Raspeburg18. Funeral director Lassahn Funeral HomeAddress 7401 Belair Road19. 1/8 19 46 Mrs. G. L. Reifsnider  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1946 1.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 6 1945 to Nov 12 1945  
and that I last saw her alive on Nov 13 1945

Immediate cause of death

DURATION

Coronary arteriosclerosis  
Due to  
arteriosclerotic heart  
disease  
Due to

Other conditions

cerebral arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or otherAddress Ridge Rd. Bto-6 Date signed 1/7/46

RECEIVED

STATE OF TEXAS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 00209 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 41 years, 7 mos., 27 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 41 years, 7 mos., 27 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Reinhart Fernum

## 3.(b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife ?  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 1862  
 8. AGE: Years 84 Months ? Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace New York  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business Unknown  
 12. Name ?  
 13. Birthplace ?  
 14. Maiden name ?  
 15. Birthplace ?

16. Informant Hospital records  
 Address Catonsville-28, Md.  
 17. Burial ? Date thereof 1-30-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Spring Grove State Hospital  
 Location Catonsville 28, Maryland  
 18. Funeral director Spring Grove State Hospital  
 Address Catonsville 28, Maryland

19. Jan. 31 1946  
 (Date rec'd by registrar) Harry H. Miller Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH January 24 1946 at 6:45 p.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 28 1894 to January 24 1946  
 and that I last saw him alive on January 24 1946

Immediate cause of death Acute exacerbation DURATION 25 days  
 Due to Chronic myocardial insufficiency Indef.  
 Due to Arteriosclerotic cardiovascular disease " "  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Isadore Tuerk M.D. or other  
Isadore Tuerk, M.D. M.D. or other  
 Address Catonsville-28, Md. Date signed 1-28-46

83300

RECEIVED

RECEIVED

RECEIVED

FEB 2 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

00210

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since May 17, 1944  
 Hospital, institution, or street address where death occurred:  
Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since May 17, 1944

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto City  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 3912 Belvidere Ave  
 (If rural, give LOCATION)

2.(a) If veteran, name war 215-16-7921 ✓

## 3. (a) FULL NAME

Wilhelmine (Fetters) Fetters

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb 12, 1911 8. (c) If alive, give age..... years

8. AGE: Years 34 Months 11 Days      If less than one day  
 .....hrs. ....min.

9. Birthplace Germany  
 (Town, county, and state)

10. Usual occupation Waitress

11. Industry or business

12. Name John Fetters

13. Birthplace Germany

14. Maiden name unknown?

15. Birthplace Germany

16. Informant Personal History Hospital Records

Address Eudowood Sanatorium Towson 4, Md.

17. Burial Date thereof 2/14/1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mountland Memorial Park

Location City

18. Funeral director Wells-Fetters Funeral Home

Address 2008 Orleans St

19. Mr 46 19 46  
 (Date rec'd by registrar)

Registrar GA

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 19 46 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1944 to Jan 31, 1946

and that I last saw her alive on January 31, 1946

Immediate cause of death..... DURATION

Pulmonary tuberculosis Since 1937

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE William A. Bridges M. D. or other

Address Towson 4 Maryland Date signed 1-31-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town CATONSVILLE  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

52 WINTERS LANE

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Catonville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 52 Winters Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

LARKIN FIELDS

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 18618. AGE: Years 84 Months 5 Days        If less than one day        hrs.        min.9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Lewis Fields13. Birthplace Va.14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. Viola FieldsAddress 52 Winters Lane17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 1-17-46  
(month) (day) (year)Cemetery or crematory Western Star Cem.Location Catonville, Balto. Co., Md.18. Funeral director Mrs. Frances A. HemsleyAddress 578 W. Biddle St.19. 1-16 19 46 A.W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13<sup>th</sup> 19 46, at 4:50 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8<sup>th</sup> 19 46 to Jan 13<sup>th</sup> 19 46and that I last saw him alive on Jan 13<sup>th</sup> 19 46Immediate cause of death Left Hemiplegia DURATION 6 daysDue to Hypertensive-arterio-sclerotic Heart Disease ?Other conditions       

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. F. Maloney, M.D. M. D. or otherAddress Catonville, Md. Date signed 1/13/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *13P*

## CERTIFICATE OF DEATH

00212

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Mount Wilson  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs., 11 mos., 8 daysHospital, institution, or street address where death occurred: Mt. WilsonBranch, Md. Tuberculosis SanatoriumHow long in hospital or institution? 3 yrs., 11 mos., 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_City or town Baltimore, Maryland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2908 W. Lafayette Ave., Balto., Md.  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

George Foster

## 3.(b) Social Security Number

212-05-84964. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Mrs. Mamie Foster6.(c) If alive, give age Unknown Years7. Birth date of deceased (mo., day, yr.) November 16, 18978. AGE: Years 48 Months 1 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Baltimore, Maryland  
(Town, county, and State)10. Usual occupation Crane Operator

11. Industry or business \_\_\_\_\_

FATHER 12. Name James Foster13. Birthplace Baltimore, MarylandMOTHER 14. Maiden name Maggie Lockman15. Birthplace Baltimore, Maryland16. Informant George FosterAddress 2908 W. Lafayette Ave., Balto. Md.17. Burial Date thereof Jan. 12, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid Ridge CemeteryLocation Reisterstown Rd., Maryland18. Funeral director Wm. Tickner & SonsAddress Pa. & North Aves., Balto., Md.19. 1/9/46 19 \_\_\_\_\_  
(Date rec'd by Registrar) Registrar Earl T. Webster

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1946 at 4:30 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1, 1942 to Jan. 9, 1946and that I last saw him alive on January 9, 1946Immediate cause of death Pulmonary Tuberculosis DURATION 21 yrs.Due to Tubercle Bacilli

Due to \_\_\_\_\_

Other conditions Tuberculous Laryngitis 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations No operationAutopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stewart S. Shaffer M.D. M.D. or other \_\_\_\_\_Address Mount Wilson, Md. Date signed 1/9/46

RECEIVED  
JAN 14 1946  
BUREAU

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH 00213

## 1. PLACE OF DEATH

County

Village or City

Length of residence in city or town where death occurred

9 yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

## 2. FULL NAME

(a) Residence: No.

(Usual place of abode)

Ward.

Registration Dist. No.

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

widow

5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

John Frampton

6. DATE OF BIRTH (month, day, and year)

7. AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BDDKKEEPER, etc.9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.10. Data deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation12. BIRTHPLACE (city or town)  
(State or country)

13. NAME

14. BIRTHPLACE (city or town)  
(State or country)

15. MAIDEN NAME

16. BIRTHPLACE (city or town)  
(State or country)17. INFORMANT  
(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place

19. UNDERTAKER  
(Address)

20. FILED

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

Jan 9 1946  
(Month) (Day) (Year)

22.

I HEREBY CERTIFY That I attended deceased from

1938 to Jan 9 1946  
I last saw her alive on Jan 3 1946; death is said

to have occurred on the date stated above, at 3 45 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:Chronic Myocarditis  
with hypertension

Date of onset

8 yrs.

Other Contributory Causes of importance:

Arteriosclerosis

8 yrs.

Name of operation

Date of

What test confirmed diagnosis? Histology. Was there an autopsy? Yes

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur?

(Specify city or town, county and State)

Specify what injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed)

(Address)

M. D.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00214

P.

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 28 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Ft. Howard, Maryland  
 How long in hospital or institution? 28 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1308 N. Mount St.,  
 (If rural, give LOCATION)  
 2 (c) If veteran, name war WW-I ✓

## 3. (a) FULL NAME

SAMUEL J. FRAZIER

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife Widowed  
 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 10-3-93  
 8. AGE: Years 52 Months 3 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business \_\_\_\_\_

12. Name Edward Frazier

13. Birthplace Maryland

14. Maiden name Kate Brown

15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Ft. Howard, Md.

17. Burial Date thereof Feb. 5, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Baltimore National Cemetery  
Baltimore, Md.  
 Location \_\_\_\_\_

18. Funeral director Metropolitan Funeral Home  
 Address 927 N. Mount St., Balto., Md.

19. 2-1 46 Armed and  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 19 46 at 9:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3, 19 46 to January 31, 19 46  
 and that I last saw him alive on January 31, 19 46

Immediate cause of death Pulmonary Tuberculosis, far, adv.  
active DURATION 3 Yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Syphilis, latent, late  
Arteriosclerosis, generalized  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. M. Balter  
A. M. BALTER, LT. COL., M.C.P. CLIN. DIR.  
 Address Ft. Howard, Md. Date signed 2-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore

93-2

# CERTIFICATE OF DEATH

00215

ρ

Reg. Dist. No. ....

1. PLACE OF DEATH: County <u>SPARROWS PT. MD</u> City or town <u>SPARROWS PT. MD</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>MD</u> County <u>SO. MARY</u> City or town <u>CALBLY</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u></u> (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>ADA FRIESS</u>				3. (b) Social Security Number			
4. Sex <u>F</u>		5. Color or race <u>W.</u>		6. (a) Single, married, widowed, or divorced <u>Widow</u>			
6. (b) Name of husband or wife <u>Ernest C. Friess</u>				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>May 13, 1890</u>							
8. AGE: Years <u>55</u>		Months <u>8</u>		Days <u>3</u>		It less than one day	
						hrs. min.	
9. Birthplace <u>Solomons Island Md</u> (Town, county, and state)							
10. Usual occupation <u>at home</u>							
11. Industry or business							
12. Name <u>Erving Weeks</u>							
13. Birthplace <u>New York</u>							
14. Maiden name <u>Sarah E. New</u>							
15. Birthplace <u>Virginia</u>							
16. Informant <u>Mo. Glanetta Deth</u>							
Address <u>3010 E. Fayette St</u>							
17. <u>Removal</u> Date thereof <u>1/17/46</u> (Burial, cremation, or removal, Which?) (month) (day) (year)							
Cemetery or crematory <u>Old Saint</u>							
Location <u>CALBLY MD</u>							
18. Funeral director <u>Ulrich Funeral Home</u>							
Address <u>2008 Orleans St</u>							
19. <u>1-17</u> 19 <u>46</u> (Date rec'd by registrar)				Registrar			
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>JAN. 16</u> 19 <u>46</u> at <u>5:15 P.</u>							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>18 mos.</u> to <u>19</u> and that I last saw him <u>alive</u> on <u>19</u>							
Immediate cause of death <u>Myocarditis</u>							
Due to <u>Arterio-Sclerosis</u>							
Due to <u>MYOCARDIAL DILATATION</u>							
Other conditions							
(Include pregnancy within 3 months of death)							
Major findings of operations							
Autopsy results							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following:							
Accident, suicide, or homicide							
Where did injury occur? (City or town) (County) (State)							
Injured at home, farm, industry, public place (where?)							
Means of injury Injured at work?							
23. SIGNATURE <u>M B Davis M.D.</u> Phys. rec'd. Gram. <u>Sally Co.</u> M. D. or other <u>MD</u> Address <u>Frederick Md</u> Date signed <u>1-16-46</u>							



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1220

## CERTIFICATE OF DEATH

00215

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Old Court Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)Street No. Old Court Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John T. Fryfogle

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

August 27, 1858

6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

8746

hrs.

min.

## 9. Birthplace

Woodlawn, Md.

(Town, county, and state)

## 10. Usual occupation

Retired Farmer

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Henry Fryfogle

## 13. Birthplace

Baltimore County, Md.

## 14. Maiden name

Mary Jane Owings

## 15. Birthplace

Baltimore County, Md.

## 16. Informant

Mrs. Edward Fryfogle

## Address

Old Court Road, Woodlawn

## 17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan. 4, 1946

(month) (day) (year)

## Cemetery or crematory

Mt. Olive Cemetery

## Location

Randallstown, Md.

## 18. Funeral director

## Address

4510 Liberty Heights Ave.

## 19.

1/2/46  
(Date rec'd by registrar)

19.

Wm. E. Martin  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 19 46 at 1:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 2, 1945 to Jan. 2, 1946and that I last saw him alive on Jan. 1, 1946

Immediate cause of death

Peritonitis

## DURATION

Due to

Strangulated Hernia & gangrene

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

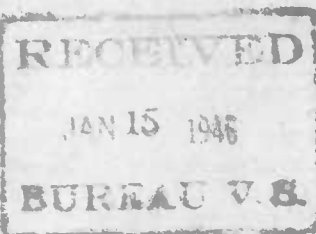
Injured at work?

23. SIGNATURE

Wm. E. Martin

M. D. or other

Address Harrisonville, Md. Date signed 1/2/46



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 33

### 1. PLACE OF DEATH:

County Baltimore  
City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 42 years  
Hospital, institution, or street address where death occurred:  
Berrymans Lane & Deer Park Road  
How long in hospital or institution? -

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Berrymans Lane & Deer Park Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war. No

### 3. (a) FULL NAME

Minnie Wilhemina Gauss

### 3. (b) Social Security Number

None

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced W.

6. (b) Name of husband or wife Jacob Gauss

8. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) July 30 1868

8. AGE: Years 77 Months 5 Days 19 If less than one day - hrs. - min.

9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business -

12. Name Unknown

13. Birthplace -

14. Maiden name Albert

15. Birthplace Germany

16. Informant Mrs Katherine Hoffman

Address Reisterstown Md

17. Burial Date thereof January 22-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge Cemetery

Location Pikesville Md

18. Funeral director Wm Berryman & sons

Address Reisterstown Md

19. 1-22 1946 Mary B. Eline  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19-46 at 3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-46 to 1-19-46

and that I last saw her alive on 1-19-46

Immediate cause of death myocarditis (chronic)

Due to hypertension

Due to arteriosclerosis

Other conditions Dropsy

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE M. B. Eline M. D. or other

Address Reisterstown Md Date signed 1-21-46

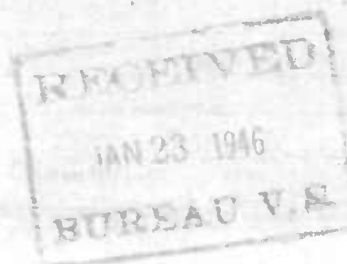
MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00217

CERTIFICATE OF DEATH



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

00218

44

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County.....Baltimore  
 City or town.....Spawtons Point 19  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....25 years  
 Hospital, institution, or street address where death occurred:  
7310 Bayfront Rd.  
 How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... County.....  
 City or town.....Box # 1  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

### 3. (a) FULL NAME

Catherine Geis

### 3. (b) Social Security Number

none

#### 4. Sex

Female

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Widowed

#### 6. (b) Name of husband or wife

Henry Geis

#### 7. Birth date of deceased (mo., day, yr.)

Aug 6 - 1880

#### 6. (c) If alive, give age..... years

#### 8. AGE:

Years.....65 Months.....5 Days.....3  
 If less than one day..... hrs. .... min.

#### 9. Birthplace

Baltimore City, Md.  
 (Town, county, and state)

#### 10. Usual occupation

Store Keeper (retired)

#### 11. Industry or business

Proceries

#### 12. Name

Nicholas Geis

#### 13. Birthplace

Ireland

#### 14. Maiden name

Mary Cox

#### 15. Birthplace

England

#### 16. Informant

Ed Croucher (son)

#### Address

Box # 1

#### 17. Burial (Burial, cremation, or removal. Which?)

Burial Date thereof.....1-12-46  
 (month) (day) (year)

#### Cemetery or crematory

St. Mary's Cemetery

#### Location

German Hill Road

#### 18. Funeral director

Phy. C. Mally, Inc.

#### Address

2435 E. Oliver St

#### 19. (Date rec'd by registrar)

1-10 1946

Ed Croucher  
 Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....Jan 9 1946 at 11:50 A. M.

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

illness.....1946 to Jan 9 1946

and that I last saw him/her alive on Jan 9 1946

#### Immediate cause of death

Coronary Thrombosis

#### DURATION

2 wks.

#### Due to

Arteriosclerosis

#### Due to

2 years

#### Other conditions

.....

(Include pregnancy within 3 months of death)

#### Major findings of operations

..... Date of op. ....

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

#### 23. SIGNATURE

R. M. Lee M. D. or other  
6908 N. P. St.  
 Address.....Baltimore 14 Md. Date signed.....1/9/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 06206 31

### 1. PLACE OF DEATH:

County Baltimore

City or town Randallstown (rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, institution, or street address where death occurred:  
Old Court-Road

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Randallstown (rural)  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Old Court-Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Minnie R. Metz

### 3. (b) Social Security Number

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife John Metz

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1869

6.(c) If alive, give age years

8. AGE: Years 76 Months 1 Days 16  
If less than one day hrs. min.

9. Birthplace Pennsylvania  
(Town, county, and state)

10. Usual occupation Retired

### 11. Industry or business

12. Name Reuben Kohr

13. Birthplace Pennsylvania

14. Maiden name Eliza Fink

15. Birthplace Pennsylvania

16. Informant Mrs. Frank Buch

Address Old Cr. Rd. Balto.

17. Burial Date thereof Jan. 31, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location York, Pa.

18. Funeral Director Wm. J. Tickner & Sons

Address North & Penna Ave

19. 1/28/46 W. E. Martin  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28, 1946 1000 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940, to Jan. 28, 1946

and that I last saw her alive on Jan. 28, 1946

Immediate cause of death

Coronary thrombosis

Due to Atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or other

Address Randallstown Date signed 1/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JAN 31 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 00219

## 1. PLACE OF DEATH:

County... 7014 Holabird AveCity or town... Dundalk Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... DundalkCity or town...  
(If outside city or town limits, write RURAL and give nearest town)Street No...  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John Gigliotti

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife... Grace Serianini

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Oct. 8 1881

## 8. AGE:

64

Years

Months

2

Days

24

If less than one day

hrs. min.

9. Birthplace... Platino Italy

(Town, county, and state)

10. Usual occupation... Tavern Owner11. Industry or business Inn12. Name... Angelo Gigliotti13. Birthplace Italy14. Maiden name... Philomena Fragalo15. Birthplace Italy16. Informant... (Son) Joseph GigliottiAddress 7010 Holabird Ave17. Burial Date thereof Jan. 4 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Sacred HeartLocation German Hill Rd.18. Funeral director... Frank Pella ViceAddress 52 N. Monky St19. 1/3 W. A. Hedges  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1946 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 18 1945 to Jan. 1 1946and that I last saw him alive on Jan. 1 1946Immediate cause of death... Carcinoma of the head of the pancreas with metastasis

DURATION

Due to

Due to

Other conditions... Bronchial Asthma 3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE... Eugene F. New M.D.Address... 7001 Mornington Rd. Dundalk Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00220

Reg. Dist. No. 80

## 1. PLACE OF DEATH:

County Howard BaltimoreCity or town Catonsville, MD.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

House In The Pines

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Sandy Spring MD.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Miss. Mary Gilpin

## 3.(b) Social Security Number

No

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Single6.(b) Name of husband or wife None7. Birth date of deceased (mo., day, yr.) May. 29. 1852  
6.(c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

93 YearsMonths 7Days 11

if less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Sandy Spring, MD.  
(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

None12. Name Alvin Gilpin13. Birthplace Sandy Spring, MD.14. Maiden name Rachel Ellicott15. Birthplace Ellicott City, MD.16. Informant R. B. ThomasAddress Sandy Spring, MD.17. Burial Date thereof Jan. 12 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Woodside, MD.Location Brinklow, MD.18. Funeral director ROY W. BarberAddress Laytonsville, MD.19. Jan. 12 19 46  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 19 46 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 6 19 43 to Jan 9 19 46  
and that I last saw him alive on Jan 9 19 46

Immediate cause of death

Myocardial Insufficiency

DURATION

1205Due to Generalized Atherosclerosis7.

Due to \_\_\_\_\_

Other conditions Dense Dementia5yr.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE William K. Gallager M.D.

M. D. or other

Address \_\_\_\_\_ Date signed Jan 12 1946

CERTIFICATE OF DEATH

DECEASED

PLACE OF DEATH

RESIDENCE OF DECEASED

RECEIVED  
JAN 14 1946  
BUREAU V

MASSACHUSETTS DEPARTMENT OF HEALTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3/

00221

## 1. PLACE OF DEATH:

County BaltimoreCity or town Randallstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

Randallstown

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Randallstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. Randallstown  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William L. Gordon

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorcedmarried6.(b) Name of husband or wife Margaret C. Gordon8.(c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) Jan. 23, 18728. AGE: Years 74 Months 2 Days 2 If less than one day  
hrs. min.9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation B+ Inspector (retired)

11. Industry or business

12. Name John A. Gordon13. Birthplace Virginia14. Maiden name Margaret Blankner15. Birthplace Virginia16. Informant V. H. HurleyAddress 26 Sherwood Ave, Pikesville17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 1/23/46  
(month) (day) (year)Cemetery or crematory Mt. Lebanon CemeteryLocation Winchester, Virginia18. Funeral director Mr. J. Tuckner & SonsAddress Berlin & North Ave19. 1/25/46 Mr. E. Martin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25, 1946 at 10 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
1943 to Jan. 25, 1946  
and that I last saw him alive on Jan. 24, 1946Immediate cause of death Carcinoma of Colon

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mr. E. Martin M. D. or otherAddress Randallstown Date signed 1/25/46

15500

RECEIVED

CENTRAL BUREAU OF INVESTIGATION

RECEIVED  
JAN 31 1946  
BUREAU V R



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-6

00222

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:  
 County Baltimore  
 City or town Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 years  
 Hospital, institution, or street address where death occurred:  
69 Burke Avenue  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 69 Burke Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME Oliver Goldsboro Gore 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Lulu Todd Gore  
 7. Birth date of deceased (mo., day, yr.) Jan. 27, 1877 6. (c) If alive, give age 63 years  
 8. AGE: Years 68 Months 11 Days 27 If less than one day  
 .... hrs. .... min.

9. Birthplace Dorchester Co., Maryland  
 (Town, county, and state)  
 10. Usual occupation Painting Contractor  
 11. Industry or business Self  
 12. Name Noah E. Gore  
 13. Birthplace Maryland  
 14. Maiden name Sarah Todd  
 15. Birthplace Maryland

16. Informant Mrs. Lulu T. Gore  
 Address 69 Burke Ave., Towson, Md.

17. Burial Date thereof Jan. 26, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Parkwood Cemetery  
 Location Parkville, Maryland

18. Funeral director John Buisson's Sons  
 Address Towson, Maryland

19. 1-26- 19 46  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 19 46, at 9<sup>15</sup> P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19 44 to Jan. 24 19 46  
 and that I last saw him alive on Jan 24 19 46

Immediate cause of death Carcinomatosis DURATION 34 yrs.

Due to Carcinoma of Prostate Gland 1 1/2 yrs.

Due to  
 Other conditions  
 (Include pregnancy within 8 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Wm. H. Adelman, M.D. M. D. or other  
 Address Towson 4 Md Date signed 1/26/46

RECEIVED  
FEB 3 1946  
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 191-20

## CERTIFICATE OF DEATH

00223

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 6 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution?..... 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Prince George  
 City or town..... Mt. Rainier  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3714 - 35th Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Emily Green

## 3.(b) Social Security Number

4. Sex..... female..... 5. Color or race..... white..... 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Leonard Green  
 6.(c) If alive, give age..... 66..... years  
 7. Birth date of deceased (mo., day, yr.)..... September 27, 1879  
 8. AGE: Years..... 66..... Months..... 4..... Days..... 1..... If less than one day..... hrs. .... min.

8. Birthplace..... England  
 (Town, county, and state)  
 10. Usual occupation..... Housewife  
 11. Industry or business..... Home  
 12. Name..... David White  
 13. Birthplace..... England  
 14. Maiden name..... Emma Gillette  
 15. Birthplace..... England

18. Informant..... Hospital records  
 Address..... Catonsville-28, Md.  
 17. Burial..... Date thereof..... 1/31/46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Fort Lincoln  
 Location..... D. C. Line & Bleakly Rd. Md.  
 18. Funeral director..... Wm. J. Galley  
 Address..... 3200 - 3rd Ave. Mt. Rainier Md.

19. 1-29..... 1946  
 (Date rec'd by registrar) Registrar..... Harry D. Miller  
Deputy

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 28..... 19. 46..... at 7:45 a.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 22..... 19. 46..... to January 28..... 19. 46  
 and that I last saw h. or alive on January 28..... 19. 46

Immediate cause of death..... Uremic poisoning..... DURATION..... 4 days  
 Due to..... Hypertensive cardiovascular renal disease..... Indef.  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results..... as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... Isidore Turk, M.D...... M. D. or other  
 Address..... Catonsville-28, Md...... Date signed..... 1-28-46

RECEIVED  
JAN 29 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence of the change of  
the birthdate of the decedent  
is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00224

FILM No. 104 JUL 12 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

### 1. PLACE OF DEATH:

County Baltimore

City or town Granite  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County —

City or town Granite  
(If outside city or town limits, write RURAL and give nearest town)

Street No. St. Paul ave  
(If rural, give LOCATION)

2. (a) If veteran, name war —

### 3. (a) FULL NAME

Mary Gertrude Greenwalt

### 3. (b) Social Security Number

#### 4. Sex

Female

#### 5. Color or race

white

#### 6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife Joseph F. Greenwalt

7. Birth date of deceased (mo., day, yr.) June 15, 1847/1852

8. AGE: Years 93 Months 6 Days 19 If less than one day — hrs. — min. —

9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation housework

#### 11. Industry or business

12. Name Conrad E. Gold

13. Birthplace Germany

14. Maiden name Mary Brown

15. Birthplace Germany

16. Informant Agnes L. Gosnell

Address Granite Maryland

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 1/7/46  
(month) (day) (year)

Cemetery or crematory Holy Family

Location Harrisonville, Maryland

16. Funeral director Frank H. Newell

Address Pikesville, Maryland

19. 1/4/1946 Frank E. Martin  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4 1946, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946, to Jan 4 1946, and that I last saw her alive on Jan 3 1946

Immediate cause of death Myocarditis

Due to arteriosclerosis

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Frank E. Martin

M. D. or other —

Address Randalltown

Date signed 1/4/46

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED

JAN 15 1946

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

## CERTIFICATE OF DEATH

Reg. Dist. No. 00225 2/0

## 1. PLACE OF DEATH:

County BaltimoreCity or town Kingsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Unknown  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Esther Greer

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Estel Greer

7. Birth date of deceased (mo., day, yr.)

Nov. 2nd 1914

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

31129

hrs.

min.

9. Birthplace

Fawn Township Pa.  
(Town, county and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Stewart Matthews

13. Birthplace

Fawn Township Pa.

MOTHER

14. Maiden name

Maryde Hitchcock

15. Birthplace

Harford Co. Maryland

16. Informant

Mr. W. Howard Platt

Address

Fawn Grove Pa.

17. Burial

(Burial, cremation, or removal) (Which?)

Date thereof

1/4/1946  
(month) (day) (year)

Cemetery or crematorium

St. Paul's, Harford Co. Md.

Location

Harford Co. Maryland

18. Funeral director

Lassahn Funeral Home

Address

7401 Belair Road19. 1-2-46  
(Date rec'd by registrar)John D. Hightower  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1946 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death Fractured skull, multiplecompoundFracture neck, cervical spineFracture right humerus, compoundDue to Auto Accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto accident Date of 1/1/46Where did injury occur? Kingsville Baltimore Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury Auto accident Injured at work? No

23. SIGNATURE

Rollin C. Hudson MD DME.  
M. D. or otherAddress Towson 4, Md.Date signed 1/1/46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

RECEIVED  
JAN 8 1946  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00226

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County... Reisterstown - Md.  
 City or town... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Reisterstown  
 City or town... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Virginia Avenue  
 (If rural, give LOCATION)

2.(c) If veteran, name war

## 3. (a) FULL NAME

Caroline S. Grimmel

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced M -

6.(b) Name of husband or wife Conrad Grimmel

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE: Years 78 Months 4 Days 11 It less than one day  
 hrs. min.

9. Birthplace Balta - Md.

(Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER

12. Name ✓13. Birthplace ✓

MOTHER

14. Maiden name ✓15. Birthplace ✓16. Informant Mr. Henry KempplingAddress 2316 Mayfield Ave17. (Burial, cremation, or removal) Which? Burial Date thereof 1-21-46Cemetery or crematory David RidgeLocation Baltimore18. Funeral director Leonard J. KuckAddress 5305 Bal Harbor Road

19. (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18- 19 46 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h.e.r. alive on 1-17-46

Immediate cause of death

Cerebral hemorrhageDue to arteriosclerosisDue to hypertensionOther conditions nephritis - chronic

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John S. Sapell M. D. or otherAddress Reisterstown Md Date signed 1-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

## CERTIFICATE OF DEATH

00227 26 44  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

2. (a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

A. G. Kidrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him

alive on

19

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bd*

## CERTIFICATE OF DEATH

Reg. Dist. No. *00228 3d*

## 1. PLACE OF DEATH:

County *Baltimore*City or town *Catonville*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Baltimore*City or town *Catonville*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *406 Gayles ave*  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

*Abraham E Hall*

## 3. (b) Social Security Number

4. Sex <i>Male</i>	5. Color or race <i>Colored</i>	6.(a) Single, married, widowed, or divorced <i>married</i>	
6.(b) Name of husband or wife <i>Beatrice Hall</i>			
6.(c) If alive, give age <i>44</i> years			
7. Birth date of deceased (mo., day, yr.) <i>3 25 - 1901</i>			
8. AGE: <i>44</i> Years	Months	Days	If less than one day hrs. min.

9. Birthplace *Catonville*  
(Town, county, and state)10. Usual occupation *Teacher*

## 11. Industry or business

12. Name *George Hall*13. Birthplace *Catonville*14. Maiden name *Annie Hemon*15. Birthplace *Catonville*16. Informant *Beatrice Hall*Address *406 Gayles ave*17. *Burial* Date thereof *2-2-1946*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Greenwood Park*Location *Baltimore Co.*18. Funeral director *Mrs. Frances A. Hemmley*Address *578 W Biddle st*19. *2-1* 19 *46* *Harry W. Hillen*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan 29<sup>th</sup>* 19 *46* at *6:30 P*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 22 - 1949* to *Jan 29 - 1946*and that I last saw him alive on *Jan 29<sup>th</sup> 1946*

Immediate cause of death

*Cerebral Hemorrhage**Hypertensive Vascular Disease*

Other conditions

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *C. F. Maloney, M.D.*Address *Catonville, Md* Date signed *1/30/46*

RECEIVED  
FEB 3 1946  
BUREAU V.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

06229

44

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Baltimore  
City or town Sparrows Point Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Sparrows Point  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Penwood Road Route 10 #311  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Anna M Hammond

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Elmer E Hammond

7. Birth date of deceased (mo., day, yr.) April 11 1865 6.(c) If alive, give age..... years

8. AGE: Years 80 Months 8 Days 21 If less than one day  
..... hrs. .... min.

9. Birthplace Pennsylvania  
(Town, county, and state)

10. Usual occupation At Home

### 11. Industry or business

12. Name George Cain 13. Birthplace Pennsylvania

14. Maiden name Eliz. Sweigert 15. Birthplace Pennsylvania

16. Informant Wm. M. Hammond  
Address Penwood Rd. Sparrows Pt. Route

17. Burial Date thereof Jan 4 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Middletown Cemetery Pa.  
Location Penna.

18. Funeral director Loughlin Funeral Home  
Address 7401 Belair Road

19. Jan 3 46 Dorothy L. Farrow  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1946 12.15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1945 to Jan 2 1946  
and that I last saw him alive on Jan 1 1946

Immediate cause of death Left Ventricular Heart Failure DURATION 3 days

Due to myocardial infarction  
atherosclerotic cardiovascular disease

Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of Injury Injured at work?

23. SIGNATURE Wm. M. Hammond, M.D.  
Address 520 1st St. S.E. P.O. 19 Date signed 1.3.46  
M. D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Supply every item of information especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

INVESTIGATION OF DEATH

CERTIFICATE OF DEATH

RECEIVED  
JAN 7 1946  
BUREAU V.R.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00230

Reg. Dist. No. 31

### 1. PLACE OF DEATH

County Baltimore

City or town Parkville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Parkville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2934 Faith Hill Ave  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

Philip C. Hammond

### 3. (b) Social Security Number

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife May Ellen

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1849

8. AGE: Years 96 Months 8 Days 13 If less than one day hrs. min.

9. Birthplace Baltimore  
(Town, county, and state)

10. Usual occupation retired

11. Industry or business

12. Name David Hammond

13. Birthplace md.

14. Maiden name Hannah Tighman

15. Birthplace md.

16. Informant Mrs. Hannah J. Faid

Address 2934 Faith Hill Ave

17. Burial Date thereof 1-30-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore Cem.

Location Baltimore, Md.

18. Funeral director Reynold J. Rush

Address 3305 Harford Rd.

19. 1/29/46 Registrar Ch. H. Deane

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 19 46 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 44 to Jan 27 19 46

and that I last saw him alive on Jan 27 19 46

Immediate cause of death Heart failure

General Sinit Degeneration

Due to Advanced age

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry A. Long Jr. D

M. D. or other

Address 7113 York Rd

Date signed Jan 29, 1946

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

see Reg. 1118 and 1119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 752

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Sparrows Point  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Sparrows Point  
(If outside city or town limits, write RURAL and give nearest town)Street No. 502 E St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Barrie A. Hand

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Joseph H. Hand7. Birth date of deceased (mo., day, yr.) April 3, 1869 6.(c) If alive, give age 77 years8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Ohio  
(Town, county, and state)10. Usual occupation None11. Industry or business None12. Name Louis A. Berger13. Birthplace unknown14. Maiden name Leah Riden15. Birthplace unknown16. Informant Mr Charles HandAddress 502 E. St. Sparrows Point17. (Burial, cremation, or removal, Which?) Burial Date thereof Jan 22, 1946  
(month) (day) (year)Cemetery or crematory Cedar HillLocation Annapolis Blvd18. Funeral director John J. Henry IncAddress 715 Light St.19. Jan 21, 1946 Dawson T. Harbor  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1946 at 3:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 2, 1945 to January 19, 1946 and that I last saw him Jan 18, 1946 alive onImmediate cause of death myocardial degeneration DURATION one yearDue to Chronic Myocarditis one yearDue to Arteriosclerosis 7Other conditions general

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dawson T. Harbor M. D. or otherAddress Sparrows Point Md Date signed 1/21/46

RECEIVED

JAN 23 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00232

## CERTIFICATE OF DEATH

Reg. Dist. No. 30-

## 1. PLACE OF DEATH:

County Baltimore.  
 City or town Rural near Parkton.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 67 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland. County Baltimore.  
 City or town Rural near Parkton.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Wiseburg  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Annie Olivia Hare.

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife Daniel Howard Hare.  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 19, 1875.  
 8. AGE: Years 70 Months 8 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Parkton, Md. R.D.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own home.  
 FATHER 12. Name William Jones.  
 13. Birthplace Md.  
 MOTHER 14. Maiden name Eliza Riley.  
 15. Birthplace Md.

16. Informant Howard Hare.  
 Address Parkton, Md. R.D.  
 17. Burial. Date thereof January 14, 1946.  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Wiseburg Cemetery  
 Location Parkton, Md. R.D.  
 18. Funeral director Joseph Hartenstein  
 Address New Freedom, Pa.

19. Jan 15 1946 Chick L. Fisher  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1946 at 12:30 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 37 to Jan. 11, 1946  
 and that I last saw him alive on Jan. 10, 1946

Immediate cause of death Chronic myocarditis  
 DURATION  
 Due to  
 Due to  
 Other conditions Hypertension, hypertrophic  
cardiomyopathy, chronic bronchitis  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of Injury Injured at work?

23. SIGNATURE M. W. France  
Parkton, Md. M. D. or D.P.H.  
 Address Date signed 1/12/46



RECEIVED

FEB 3 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County ~~Catonsville~~ Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year 4 months 22 days  
 Hospital, institution, or street address where death occurred:  
 Spring Grove State Hospital  
 How long in hospital or institution? 1 year 4 months 22 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3808 Falls Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Arthur Harris

## 3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
Male	White	Separated	
6. (b) Name of husband or wife Unknown			
7. Birth date of deceased (mo., day, yr.) June 17, 1874			
8. AGE:	Years	Months	Days
	71	7	5
If less than one day .....hrs. ....min.			
9. Birthplace Maryland (Town, county, and state)			
10. Usual occupation Laborer			
11. Industry or business Unknown			
FATHER	12. Name George Harris		
	13. Birthplace Maryland		
	14. Maiden name Alice Morris		
MOTHER	15. Birthplace Maryland		

16. Informant Hospital Records  
 Address Catonsville, 28, Md.  
 17. Burial Date thereof June 25/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Emma Chapel  
 Location Baltimore, Baltimore  
 18. Funeral director Pennewell & Pennewell  
 Address 3615-17 Chestnut Ave  
 19. Jan 22 1946 Harry C. A. Mead  
 (Date rec'd by registrar) Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1945, at 3:45 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1944, to January 22, 1945, and that I last saw him alive on January 22, 1945.  
 Immediate cause of death acute enteritis  
 DURATION 20 days  
 Due to Chronic myocarditis Indef  
 Due to Arteriosclerotic C-V disease "  
 Other conditions  
 (Include pregnancy within 8 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Henry C. A. Mead M.D.  
 Address Catonsville, 28, Md. Date signed 1/22/46

RECEIVED

JAN 24 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

## CERTIFICATE OF DEATH

00234

P

Reg. Dist. No. 7X

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.How long in hospital or institution? 62 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 712 S. Charles St.

(If rural, give LOCATION)

2.(a) If veteran, name war WW

## 3. (a) FULL NAME

CHARLES EDWARD HARRIS

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Negro

## 6. (a) Single, married, widowed, or divorced

Separated

## 6. (b) Name of husband or wife

Margaret Harris6. (c) If alive, give age unknown years

## 7. Birth date of deceased (mo., day, yr.)

July 13, 1891

## 8. AGE:

Years

Months

Days

If less than one day

54527

.....hrs.

.....min.

## 9. Birthplace

Washington, D.C.

(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

## MOTHER

## 12. Name

Isaac Harris

## 13. Birthplace

Richmond, Va.

## MOTHER

## 14. Maiden name

Maggie Caplin

## 15. Birthplace

unknown

## 16. Informant

Clinical Records, Vets. Adm.

## Address

Fort Howard, Md.

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

1/15/46  
(month) (day) (year)

## Cemetery or crematory

Baltimore National

## Location

Old Frederick Road

## 18. Funeral director

Charles R. Law

## Address

802 Madison Ave. Balto. Md.

## 19.

114  
(Date rec'd by registrar)

19

W. S. Caffedant

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1946, at 12:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 9 1945 to January 10 1946and that I last saw him alive on January 10 1946

Immediate cause of death

Tuberculosis, pulmonary, chr., active, far advanceddue to xxx Anemia, secondary to #1

## DURATION

1 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. M. BALTER, LT. COL. M. C. CLIN. DIRECTOR

M. D. or other

Address Fort Howard, Md.Date signed 1-10-46

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH 932

Registered No. 00235

## 1. PLACE OF DEATH: Co.

(a) Baltimore ~~Co.~~, Maryland

(b) Street address 5501 Edmondson Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5501 Edmondson Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

## 3 (a) FULL NAME

Elle M. Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widow

6 (b) Name of husband or wife John W. Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1857

8. AGE: Years 88 Months 2 Days 10 If less than one day hr. min.

9. Birthplace Frederick, Md

(Town, county, and state)

10. Usual Occupation

None

11. Industry or business

FATHER

12. Name Joseph Carlin

13. Birthplace

Md

MOTHER

14. Maiden Name Sarah Getzdenner

15. Birthplace

Md

16 (a) Informant Miss Frances Cassidy

(b) Address 1712 Sulgrave Road

17 (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Jan. 21, 1946

(month) (day) (year)

(c) Cemetery or crematory

Baltimore

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 914 Greenmount Ave

19 (a) Date rec'd by registrar

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1946, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945, to Jan 19, and that I last saw h alive on Jan 19.

Immediate cause of death

Chr. Myocarditis

Duration

2 mon

Due to Cor. Arterio Sclerosis

Cardiac Vas. Disease

2 yrs

Due to

Other Conditions

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature James H. Howell

Address 1-18 Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

## CERTIFICATE OF DEATH

00236

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County BaltimoreCity or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)Street No. Ritter Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Eliza C. Harrison

## 3. (b) Social Security Number

4. Sex Female5. Color of face White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Richard H. Harrison

deceased

7. Birth date of deceased (mo., day, yr.) March 3, 18728. AGE: Years 73 Months 10 Days 6 If less than one day

hrs. min.

9. Birthplace Carroll Co. Maryland  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Basil T. Chaney13. Birthplace Maryland14. Maiden name Mary C. Lowman15. Birthplace Maryland16. Informant Mr. Millard MillsAddress Owings Mills, Md.17. Burial Date thereof 9-12-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Morgan ChapelLocation Day, Carroll Co. Maryland18. Funeral director C. M. WauzAddress Winfield, Md.19. 1-10-46 Mary B. Ellis  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9, 1946 at 7:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1-46 to 1-9-46and that I last saw her alive on 1-8-46

Immediate cause of death

myocarditis chronicDue to hypertensionDue to arteriosclerosisOther conditions Insane

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury 7 Injured at work?23. SIGNATURE John G. Saffel M. D. or otherAddress Baltimore, Md. Date signed 1-10-46



CERTIFICATE OF DEATH

RECEIVED

JAN 14 1946

BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 months, 3 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 6 months, 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore-22  
(If outside city or town limits, write RURAL and give nearest town)Street No. 57 Northship Road  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Anna Haupt

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

femalewhitewidowed6. (b) Name of husband or wife Peter Haupt

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15, 18698. AGE: Years Months Days If less than one day  
76 11 30 hrs. min.9. Birthplace Louisville, Kentucky  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Henry Weigle13. Birthplace Germany14. Maiden name Margaret ?15. Birthplace Germany16. Informant Hospital recordsAddress Catonsville-28, Md.17. Burial Date thereof Jan 16, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Meadow RidgeLocation Rural18. Funeral director Ulrich Funeral HomeAddress 2108 Orleans St19. 1-15 19 46 Q. J. Thelander  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 19 46 at 4:00 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 19 45 to January 14 19 46and that I last saw her alive on January 14 19 46

Immediate cause of death

Chronic myocarditis

DURATION

Indef.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Turk, M.D.

M. D. or other

Address Catonsville-28, Md. Date signed 1/14/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 00238

1. PLACE OF DEATH: Baltimore  
County \_\_\_\_\_  
City or town Catonsville  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: Wood Nursing Home  
Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Stay in this community (yrs., or mos., or days) \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State md County Catonsville  
City or town Solomons Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. \_\_\_\_\_ (If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME Mrs. Susannah E. Hayden

3. (b) Social Security Number No

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W  
6 (b) Name of husband or wife Richard J. Hayden  
8 (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Apr. 5, 1857  
8. AGE: Years 88 Months 9 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Home  
11. Industry or business \_\_\_\_\_

FATHER 12. Name Robert Higgo  
13. Birthplace md

MOTHER 14. Maiden name Rosalia Hayden  
15. Birthplace md

16. Informant William Hayden  
Address Baltimore, md

17. Burial Date thereof Jan. 25, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Middleham Chapel  
Location Burby, md

18. Funeral director A. G. Haskins & Son  
Address Mutual, md

19. Jan 25 1946 Harry L. Miller Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22, 1946 60 M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1945, to Jan 22 1946, and that I last saw him alive on Jan 22 1946.

Immediate cause of death Chor Myocarditis DURATION 1 yr.

Due to Arterio Sclerotic 3 yrs  
Cardio Vasc. Disease

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James Estowes  
Address Catonsville M. D. or other \_\_\_\_\_  
Date signed 1-23

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

RECEIVED

JAN 28 1946

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... BaltoCity or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

12 Osborne Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... md County..... BaltoCity or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 12 Osborne Ave

(If rural, give LOCATION)

2.(a) If veteran, name war..... NO

## 3. (a) FULL NAME

Louis E. Hehl

## 3. (b) Social Security Number

212-16-5360

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Catherine L. Hehl

7. Birth date of

deceased (mo., day, yr.)

Oct 6<sup>th</sup> 1867

6.(c) If alive, give age..... years

8. AGE:

Years

78

Months

3

Days

6

If less than one day

..... hrs. .... min.

9. Birthplace

Biederach Germany

(Town, county, and state)

10. Usual occupation

Manager

11. Industry or business

F. Burkart Mfg. Co.

FATHER

12. Name

Frederick Hehl

13. Birthplace

Germany

MOTHER

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

Leonard E. Hehl

Address

12 Osborne Ave - Germany

17. Burial

(Burial, cremation, or removal. When?)

Burial

Date thereof

11/5/46

Cemetery or crematory

London Park

Location

Balto. md.

18. Funeral director

William Cook Inc

Address

1217 St. Paul St.19. 1-1415. 48

Date rec'd by registrar

27

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Jan 12<sup>th</sup> 1946 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March-5 1935 to..... Jan-11 1946and that I last saw him alive on..... Jan-11 1946

Immediate cause of death

Myocarditis & Coronary  
OcclusionDue to Acute Nephritis

DURATION

2-3 yr.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

NO

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. Lloyd Johnson

Address

Catonsville

Date signed

1-13-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00289

30

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hood Convalescent Home - Edmondson Ave. 5501

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5501 Edmondson Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Jeannette Heiser

## 3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>female</u>	<u>white</u>	<u>single</u>

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1863

8. AGE:	Years	Months	Days	It less than one day
	<u>82</u>	<u>1</u>	<u>25</u>	hrs. min.

9. Birthplace Baltimore County, Md.  
(Town, county, and state)10. Usual occupation retired

11. Industry or business

12. Name Charles Heiser13. Birthplace Baltimore County, Md.14. Maiden name Mary Shew15. Birthplace Baltimore County, Md.16. Informant Mrs. Ida A. Vanneman  
Address St. Paul Court Apts.17. Burial 1/17/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon ParkLocation 3801 Frederick Ave., Balto., Md.18. Funeral director John O. Mitchell & Sons, Inc.Address 1900 Eutaw Place, Balto., Md.19. 1-17-46  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 19 46, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 19, 1940 to January 15, 1946and that I last saw him alive on January 15, 1946Immediate cause of death Myocardial Infarction andEmphysemaDue to ThrombosisDue to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James R. Hoffman, M.D.Address 5528 Rusk Ave. Date signed 1/17/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-0

00241

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 years

Hospital, institution, or street address where death occurred

No 16 - Rusting AveHow long in hospital or institution? 6 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Boonsboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. St. Paul St  
(If rural, give LOCATION)2(a) If veteran, name war None ✓

## 3. (a) FULL NAME

Maud A. B. Hennelberger

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed6. (b) Name of husband or wife W. A. Hennelberger

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July - 6 - 18658. AGE: Years 80 Months 5 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Boonsboro Wash. Co. Md.  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Maud A. B. Hennelberger13. Birthplace Boonsboro Wash. Co. Md.14. Maiden name Laura Brining15. Birthplace Boonsboro Wash. Co. Md.16. Informant Lawrence HennelbergerAddress Boonsboro Md.17. Burial Date thereof Jan. 7, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Boonsboro MausoleumLocation Boonsboro Md.18. Funeral director Wm. J. Best & SonsAddress Boonsboro Md.19. 1/6 46 Larry Miller  
(Date rec'd by registrar) (year) (Signature)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1946 at 8:15 a. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 1940 to Jan. 5 1946 and that I last saw him alive on Jan. 4 1946

Immediate cause of death

Myocardial Infarction

## DURATION

3 wDue to Coronary arteriosclerosis ?Due to Chr. cardio-vascular-disease 63+

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William K. Gallager, M.D. M. D. or otherAddress Catonsville - 28, Md. Date signed 1-5-46

RECEIVED  
JAN 10 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County.....Baltimore  
 City or town.....Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 0 yrs., 1 mo., 17 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson  
Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution? 0 yrs., 1 mo., 17 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....  
 City or town.....Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 602 N. Monroe Street  
 (If rural, give LOCATION) ✓  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

Clyde P. Hill

## 3. (b) Social Security Number

218-05-9483

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Divorced</u>	
6. (b) Name of husband or wife..... <u>Clara Hill</u>		6. (c) If alive, give age..... <u>Unknown</u> years	
7. Birth date of deceased (mo., day, yr.) <u>December 17, 1896</u>			
8. AGE:	Years <u>49</u>	Months <u>1</u>	Days <u>1</u> If less than one day .....hrs. ....min.
9. Birthplace..... <u>Greensburg, Pa.</u> (Town, county, and state)			
10. Usual occupation..... <u>Steam Fitter</u>			
11. Industry or business.....			
FATHER	12. Name..... <u>George Hill</u>		
	13. Birthplace..... <u>Greensburg, Pa.</u>		
	14. Maiden name..... <u>Annie Wilson</u>		
MOTHER	15. Birthplace..... <u>Greensburg, Pa.</u>		

16. Informant.....Clyde P. Hill  
 Address.....602 N. Monroe St., Balto., Md.  
 17. Burial Date thereof.....Jan. 24, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory.....Almshouse Cemetery  
 Location.....Texas, Maryland  
 18. Funeral director.....Frank Newell, Inc.  
 Address.....Pikesville, Maryland  
 19. Jan. 18, 1946 Earl T. Webster  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....January 18, 1946 at 10:50 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 1, 1945 to Jan. 18, 1946  
 and that I last saw him alive on January 18, 1946  
 Immediate cause of death.....Pulmonary Tuberculosis DURATION 18 mos.  
Tubercle Bacilli  
 Due to.....  
 Due to.....  
 Other conditions.....Tuberculous Laryngitis 4 mos.  
 (Include pregnancy within 8 months of death)  
 Major findings of operations.....No operation Date of op.....  
 Autopsy results.....No autopsy  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE.....Stewart A. Shaffer m.d. M. D. or other  
 Address.....Mount Wilson, Md. Date signed.....1/21/46  
Rec'd 1-24-46 Dr. E. E. Nichols

RECEIVED

15N25 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Parkville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? none

## 3. (a) FULL NAME

William M. Hoerner4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower8. (b) Name of husband or wife Anna Louisa Hoerner7. Birth date of deceased (mo., day, yr.) Oct 8 1868 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 77 Months 3 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace District Columbia  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Truck Farmer12. Name John Hoerner13. Birthplace Germany14. Maiden name Unknown

15. Birthplace

16. Informant Rav Wiebking  
Address Putty Hill Ave17. Burial Burial Date thereof 1/17/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Johns LutheranLocation Harford Road18. Funeral director Lassiter Fun. HomeAddress 7401 Belair Road19. 1/15 46 G. W. Bacon  
(If late rec'd by registrar) 19 46 Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Parkville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2200 Miller Ave  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1946 1.30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 1945 to January 14 1946  
and that I last saw him live on January 7 1946Immediate cause of death Acute Coroner Dissection DURATION January 14 1946

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other condition Chronic Myocarditis  
(arteriosclerosis)  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Morris B. Green M. D. or otherAddress 3009 Eagerman av Date signed 1/14/46  
Baltimore, Md.

MAINTAIN STATE DEPARTMENT OF HEALTH

MAINTAIN STATE DEPARTMENT OF HEALTH

RECEIVED  
JAN 16 1946  
BUREAU OF



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-21

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County..... **Baltimore**  
City or town..... **Fort Howard**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... **151 Days**  
Hospital, institution, or street address where death occurred:  
**Vets. Adm. Hosp. Fort Howard, Maryland**  
How long in hospital or institution?..... **151 Days**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County.....  
City or town..... **1707 E. Oliver St. Balto. Md.**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... **See above**  
(If rural, give LOCATION)  
2. (a) If veteran, name war..... **W-I**

### 3. (a) FULL NAME

**CONRAD HOFFMAN**

### 3. (b) Social Security Number

**none**

4. Sex..... **Male** 5. Color or race..... **White** 6. (a) Single, married, widowed, or divorced..... **Married**  
(Mrs. Madeline Hoffman)  
6. (b) Name of husband or wife..... **Mrs. Conrad Hoffman**  
6. (c) If alive, give age..... **38** years

7. Birth date of deceased (mo., day, yr.)..... **8-9-86**  
8. AGE: Years..... **59** Months..... **5** Days..... **14** If less than one day..... hrs. min.

9. Birthplace..... **Maryland**  
(Town, county, and state)

10. Usual occupation..... **Unemployed**

### 11. Industry or business

12. Name..... **William Hoffman**  
13. Birthplace..... **?**  
14. Maiden name..... **Barbara ?**  
15. Birthplace..... **?**

16. Informant..... **Vets. Adm. Hosp: Clinical Records,**  
Address..... **Fort Howard, Maryland**

17. **Burial** Date thereof..... **Jan 28, 1946**  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... **Baltimore National Cemetery**  
Location..... **Baltimore, Maryland**

18. Funeral director..... **H. Sander & Sons**  
Address..... **North Ave & Broadway, Balto., Md.**

19. **Jan 26** 19 **46** **Alfred**  
(Date rec'd by registrar) (year) (month) (day) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... **January 24, 1946** 19..... at **9:45 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**August 26, 1946** 19..... to **January 24, 1946** 19.....  
and that I last saw him alive on **January 24, 1946** 19.....

Immediate cause of death..... **Nephritis, interstitial chronic**

Due to.....

Due to.....

Other conditions..... **Disease of the heart,**  
**Hypertension & Coronary arterio-**  
**sclerosis, Myocardial damage, cardiac**  
Major findings of operations..... **enlargement**

Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... **A. M. Balter**  
**A. M. BALTER, Lt. Col., M.C.** or other  
Address..... **Ft. Howard, Md.** Date signed..... **1-24-46**

MARGIN RESERVED FOR BINDING

VS A15

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 185 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.How long in hospital or institution? 185 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 204 N. High St.  
(If rural, give LOCATION)2. (a) If veteran, name war SAW

## 3. (a) FULL NAME

MATTHEW HOGAN

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife .....

8. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 13, 1875

8. AGE: Years Months Days It less than one day

70 7 4 ..... hrs. .... min.9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business .....

12. Name John Hogan13. Birthplace Whales14. Maiden name Mary Flannagan15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm.Address Fort Howard, Md.17. Buried Date thereof Jan. 22, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore NationalLocation Frederick Road18. Funeral director Ochs Funeral Home, Inc.Address 4644 YORK. RD19. 1-18 46 AWH  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 19 46 at 1:55 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 45 to January 17 19 46and that I last saw him alive on January 17 19 46Immediate cause of death ..... DURATION  
Arteriosclerotic Heart Disease unknown

Due to .....

Due to .....

Other conditions Fracture, left femurDue to: Accidental fall, congest  
(Include pregnancy within 3 months of death)Major findings of operations None

..... Date of op. ....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of July 14, 1945

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Accidental fall Injured at work? .....AWH amr Balter23. SIGNATURE A. M. BALTER, LT. COL. M. C. CLIN. DIR.  
M. D. or otherAddress Fort Howard, Md. Date signed 1-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 00248

## 1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address Edmondson Ave.
- (c) Hospital or institution: Hood Nursing Home
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore
- (c) City or town Baltimore  
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 5150 Old Frederick Rd.  
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)  
If yes, name country

## 3 (a) FULL NAME

MARY M. HOOD

3 (b) If veteran, name war  
none3 (c) Social Security Account  
No. none4. Sex  
Female5. Color or race  
White6 (a) Single, married, widowed, or  
divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 18758. AGE: Years Months Days If less than one day  
70 4 15 hr. min.9. Birthplace Frederick Co., Md.  
(Town, county, and state)10. Usual Occupation Teacher11. Industry or business Private SchoolFATHER 12. Name Ephriam Hood  
13. Birthplace Frederick Co., Md.MOTHER 14. Maiden Name Mary Buxton  
15. Birthplace Frederick Co., Md.16 (a) Informant Mrs. C. B. Porter  
(b) Address 5705 Fair Oaks Ave.17 (a) Burial (b) Date thereof 1/29/46  
(Burial, cremation, or removal) (month) (day) (year)  
(c) Cemetery or crematory Prospect Cem.  
Location Mt. Airy, Md.18 (a) Funeral director WM. J. TICKNER & SONS  
(b) Address Balto., Md.19 (a) 1/28/46 Acersmith  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26, 1946, at 11:00 A21. I certify that death occurred on the date above stated; that I attend-  
ed deceased from May 9, 1944, to Jan 26, 1946,  
and that I last saw h Jan 26, 1946 alive on Jan 26, 1946

Immediate cause of death

Duration

Coronary Arteriosclerosis  
Cardio Vas. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

## PHYSICIAN

Underline the  
cause to which  
death should be  
charged statisti-  
cally.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence \_\_\_\_\_ at \_\_\_\_\_ M
- (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public  
place? \_\_\_\_\_ While at work? \_\_\_\_\_  
(Specify type of place)

(c) Means of injury

23. Signature James H. Towse M. D.  
Address James H. Towse Date signed 1-26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on **MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore *7-2*

# CERTIFICATE OF DEATH

Reg. Dist. No. *38*

FILM No. *I 00 FEB 1 1946*

1. PLACE OF DEATH:  
County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 months, 2 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 8 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Prince George  
City or town Carmady Hills  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 203 - 74th Place  
(If rural, give LOCATION)  
2.(a) If veteran, name war ☒

3. (a) FULL NAME Helen C. Hughes 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed  
6.(b) Name of husband or wife Joseph Perry Hughes  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) October 21, 1866  
8. AGE: Years 79 Months -80- Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bridenton, Maryland  
(Town, county, and state)  
10. Usual occupation Principal  
11. Industry or business School  
12. Name Dr. Thomas A. Carrico  
13. Birthplace Maryland  
14. Maiden name Anna Dent  
15. Birthplace Kentucky

16. Informant Hospital records  
Address Catonsville-28, Md.  
17. Burial Date thereof Jan 29-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory St. Marys Cem  
Location Bryantstown Md

18. Funeral director Nunn & Ryan  
Address Waldorf Md  
19. Jan 27 46 (Date rec'd by registrar) Registrar Harry D. Mithel

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1946 at 9:50 a.m.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1945 to January 26 1946  
and that I last saw her alive on January 26 1946

Immediate cause of death Chronic myocarditis  
DURATION Indef.  
Due to Chronic hypertensive cardio-vascular disease  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other  
Address Catonsville-28, Md. Date signed 1/26/46

RECEIVED

JAN 28 1946

BUREAU T S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Baltimore

City or town Chase  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balt's

City or town Chase  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Eastern Ave. Road  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Veronica Swanczyk

### 3. (b) Social Security Number

4. Sex

F.

5. Color or race

A.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Anthony Swanczyk

6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.)

Dec. 24 - 1888

8. AGE:

Years

Months

Days

If less than one day

57

1

4

hrs.

min.

9. Birthplace

Chekoslovakia

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Mrs. Agnes Gilmore

Address

Eastern Ave. Chase

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Jan. 31 - 46  
(month) (day) (year)

Cemetery or crematory

Holy Cross

Location

Arnapolis Rd. (Ritchie Hg.)

18. Funeral director

John B. Connelly

Address

488 Eastern Ave. Chase

19. 1/30/46

(Date rec'd by registrar)

19 46

John B. Connelly

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 19 46 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 26 19 46 to Jan 28 19 46

and that I last saw him alive on Jan 28 19 46

Immediate cause of death

Acute Coronary Occlusion

DURATION

1/25/46

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Agnes Gilmore

M. D. or other

Address

488 Eastern Ave. Chase

Date signed 1/29/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.



RECEIVED  
FEB 5 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 42 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, MarylandHow long in hospital or institution? 42 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3145 Clifftmont Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war W-I

## 3. (a) FULL NAME

JACKSON, Nathaniel L.

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Marie M. Jackson6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.)

1-21-93

8. AGE:

Years

Months

Days

If less than one day

5301

..... hrs. .... min.

9. Birthplace Allentown, Pa.

(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER

12. Name John H. Jackson13. Birthplace Pennsylvania

MOTHER

14. Maiden name Flora Kulp15. Birthplace Pennsylvania16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Md.17. Burial  
(Burial, cremation, or removal. Which?)Date thereof Jan. 25, 1946  
(month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director William CookAddress St. Paul & Preston Sts., Balt. Md.19. 1-23  
(Date rec'd by registrar)44Gen. H. Cook  
Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1946 11:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 11, 1945 to January 22, 1946and that I last saw him alive on January 22, 1946

Immediate cause of death

Uremia, acute

DURATION

1/18/46Due to Carcinoma of Pancreas5 Mos.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

A. S. A. M. BALTER, LT. COL. M. D. or otherAddress Fort Howard, MarylandDate signed 1-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County BaltimoreCity or town Perry Point  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

47 Waterview RoadHow long in hospital or institution? none

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balts.City or town Perry Point  
(If outside city or town limits, write RURAL and give nearest town)Street No. 47 Waterview Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William R. Jenkins

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Nannie Shepherd

7. Birth date of

deceased (mo., day, yr.)

July 3 1869

6. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

7662

hrs.

min.

9. Birthplace

Perry Hill Station, Balts. Md.  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

Unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Frederick Jenkins

Address

1614 Northchurch Road  
Baltimore

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 8, 1946  
(month) (day) (year)

Cemetery or crematory

Lohan Presbyterian Church

Location

York Rd. Balts. Md.

18. Funeral director

James J. Myers

Address

5005 Park Heights

19.

(Date rec'd by registrar)

19

Jan 15, 1946  
Frederick Jenkins  
ask Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1946 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 3 1946 to Jan 3 1946  
and that I last saw him alive on Jan 3 1946

Immediate cause of death

myocarditis

DURATION

Due to

Due to

Other conditions

Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where and injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harry Gilbert M.D.

M. D. or other

Address 7 Beechwood Date signed 1/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

## CERTIFICATE OF DEATH

Reg. Dist. No. 00250 38

1. PLACE OF DEATH: Balto  
 County.....  
 City or town.....Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....4 1/2 yrs  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....Md. County.....Balto  
 City or town.....Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....408 E. Penn. Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME.....Pauline Johnson

3. (b) Social Security Number

4. Sex.....H. 5. Color or race.....C 6. (a) Single, married, widowed, or divorced.....Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....Nov. 12th 1891 6. (c) If alive, give age..... years

8. AGE: Years.....54 Months..... Days..... If less than one day..... hrs..... min.

9. Birthplace.....King & Queens Co. Va.  
 (Town, county, and state)  
Domestic

10. Usual occupation.....

11. Industry or business.....

12. Name.....Benjamin Johnson  
 13. Birthplace.....W.

14. Maiden name.....Mary Jane  
 15. Birthplace.....W.

16. Informant.....Mary Jane Johnson  
 Address.....36 12th St. Salem, N.J.

17. Burial.....Burial Date thereof.....1-20-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Pleasant Rest  
 Location.....Towson Md. Balto. Co.

18. Funeral director.....Baron M. Smith & W. Wright  
 Address.....721 Bisquit St. Balto. Md.

19. 1/6.....19 46  
 (Date rec'd by registrar) (month) (year)

Registrar.....W. J. J. J. J.

20. DATE OF DEATH.....Jan 2 1946 at.....5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....Jan 2 1946  
 and that I last saw him.....Jan 2 1946  
 Immediate cause of death.....Cerebral Hemorrhage  
 DURATION.....3 hrs.

## MEDICAL CERTIFICATION 46

20. DATE OF DEATH.....Jan 2 1946 at.....5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....Jan 2 1946  
 and that I last saw him.....Jan 2 1946

Immediate cause of death.....Cerebral Hemorrhage DURATION.....3 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Pauline B. Johnson M. D. or other

Address.....2329 Green St. Balto. Md. Date signed.....Jan 5 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 & 8 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.How long in hospital or institution? 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 625 E. Fort Ave.  
(If rural, give LOCATION)2(a) If veteran, name war WW ✓

## 3. (a) FULL NAME

HARRY COOPER JONES

## 3. (b) Social Security Number

217-22-1008

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MalewhiteWidowed

6. (b) Name of husband or wife .....

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) No October 17, 18888. AGE: Years Months Days If less than one day  
57 2 24 ..... hrs. .... min.9. Birthplace Hillsboro, Md.  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Thomas H. Jones13. Birthplace Hillsboro, Md.14. Maiden name Mary L. Harris15. Birthplace Hillsboro, Md.16. Informant Clinical Records, Vets. Adm.Address Fort Howard, Md.17. B Date thereof 1-14-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Western CemeteryLocation Baltimore, Md.18. Funeral director I. Few McCauleyAddress 128 E. Fort Ave. Balto. Md.19. 1-14-46 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 19 46 at 5:50A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 3 19 46 to January 11 19 46  
and that I last saw him alive on January 11 19 46Immediate cause of death ..... DURATION  
Multiple Pulmonary Infarcts unknown

Due to .....

Due to .....

Other conditions Generalized Arteriosclerosis;  
Cardiac Hypertrophy  
(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. ....

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE A.M. BALTER, LT. COL. M.C. CLIN. DIR.  
M. D. or otherAddress Fort Howard, Md. Date signed 1-11-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

00252

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Balto.

City or town Esep  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

209 Eastern Ave.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balto

City or town Esep  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 209 Eastern Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife Henry Jung

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 31 - 1894

8. AGE: Years 52 Months Days If less than one day hrs. min.

9. Birthplace Balto.  
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name John W. Wojowski

13. Birthplace Germany

14. Maiden name Unknown

15. Birthplace

16. Informant Henrick Jung

Address 209 Eastern Ave.

17. Burial Date thereof 1/26/96  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Eastern Ave. Rd.

18. Funeral director John H. Connelly

Address 418 Eastern Ave. Esep 21.

19. 1-26-96 19. John T. Connelly  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 - 19 46 at 10:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1945 to Jan 24 1946 and that I last saw him alive on Jan 24 1946

Immediate cause of death Broncho Pneumonia

Due to fractured spine & paralysis of legs.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lemay W. Hummel M. D. or other

Address Esep Md Date signed 2/6/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
JAN 28 1946  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00253

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore  
 County Ellicott City, Harford  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 71 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Ellicott City, Harford  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Frederick Road  
 (If rural, give LOCATION)  
 2(a) If veteran, name war None

3. (a) FULL NAME Kate Keller

3. (b) Social Security Number None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Frank Keller

6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) June 1st, 1866

8. AGE: Years 79 Months 7 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Elkridge, Md.  
 (Town, county, and state)

10. Usual occupation Household duties

11. Industry or business Own home

12. Name Henry Dantell

13. Birthplace Germany

14. Maiden name Mary Peathers

15. Birthplace Germany

16. Informant Mrs. Matthew Cusan

Address Ellicott City, Md.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof June 24, 1946  
 (month) (day) (year)

Cemetery or crematory Western Cemetery

Location Baltimore, Md.

18. Funeral director Easton Sons

Address Ellicott City, Md.

19. 1-22 46 Harry Sh. Miller  
 (Date rec'd by registrar) (month) (day) (year) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1946, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 30 - 1945 to January 21 - 1946

and that I last saw him alive on January 20 - 1946

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Acute dilatation of heart a few

Due to Hypertension minutes -

Due to unknown

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Chester Riland, M.D.

M. D. or other \_\_\_\_\_

Address 2532 Edmonson Ave Date signed 1-22-1946

Baltimore (23) Maryland

RECEIVED

JAN 23 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County BaltimoreCity or town Halethorpe - Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Halethorpe  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4620 Washington Blvd.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Rose Kirchhofer

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color of skin

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Jacob KirchhoferB. (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.)

Aug 15 1880

8. AGE:

Years

Months

Days

If less than one day

65614

hrs.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At home

FATHER

12. Name

Jacob Kirchner

13. Birthplace

Germany

MOTHER

14. Maiden name

Samie unknown

15. Birthplace

Germany

16. Informant

Jacob Kirchhofer

Address

4620 Washington Blvd.

17.

(Burial, cremation, or removal. Which?)

Date thereof

1/23/46

Cemetery or crematory

Cathedral Cemetery

Location

430 Old Federal Ave.

18. Funeral director

John J. Cowan

Address

901 Ballin St.

19.

(Date rec'd by registrar)

1-22 46Antkowiak

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 19 46 at 42 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 17 19 46 to Jan 20 19 46and that I last saw him alive on Jan 19 19 46

Immediate cause of death

Broncho pneumonia 3daMyocarditis 2daGeneral arteriosclerosis 2

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Cowan  
Address 901 Ballin St. Date signed 1/22/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH

County Balto.

City or town Sparrow Pt.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7707 Inguis Ave

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto.

City or town Sparrow Point # 19  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7707 Inguis Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Christian Kolb

### 3. (b) Social Security Number

4. Sex

m.

5. Color or race

wh.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Lama Kolb nee

Axringdale

7. Birth date of deceased (mo., day, yr.) Jan. 26 - 1887

6. (c) If alive, give age 68 years

8. AGE:

Years

Months

Days

It less than one day

58

11

14

hrs.

min.

9. Birthplace

Baltimore Co.

(Town, county, and state)

10. Usual occupation

Policeman

11. Industry or business

Beth Steel (Sp. Pt.)

FATHER

12. Name

Adam Kolb

13. Birthplace

Balto.

MOTHER

14. Maiden name

Louise Hazelhoff

15. Birthplace

Balto.

16. Informant

Mrs. Lama Kolb

Address

7707 Inguis Ave. Sp. Pt. 19

17.

Burial

Date thereof

Jan. 13 - 46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt. Carmel

Location

Q Donnell St. Balto.

18. Funeral director

John G. Connolly

Address

418 Eastern Ave. Essex

19.

January 13 - 1946

(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 - 1946 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 9 - 1946 to January 10 - 1946

and that I last saw him alive on January 12 - 1946

Immediate cause of death

Bronchial Pneumonia

DURATION

3 days

Due to

Influenza

one week

Due to

Acute Cardiac Failure

one day

Other conditions

Pulmonary Edema

6 hrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Dawson L. Harber

M. D. or other

Address

Sparrow Point md

Date signed

1/13/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 17 1946  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00256

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 0 yrs., 4 mos., 4 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution? 0 yrs., 4 mos., 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 21 S. Stricker Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Mrs. Susan Kulka

## 3.(b) Social Security Number

# Unknown

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Charles Kulka  
 7. Birth date of deceased (mo., day, yr.) April 5, 1919 B.(c) If alive, give age 35 years  
 8. AGE: Years 26 Months 9 Days 12 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Windber, Pennsylvania  
 (Town, county, and state)  
 10. Usual occupation Grinder in Defense Plant  
 11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name George Kisula  
 13. Birthplace Austria Swiderski  
 14. Maiden name Rose Sziderski (?)  
 15. Birthplace Austria

16. Informant Mrs. Susan Kulka  
 Address 21 S. Stricker St., Balto., Md.

17. Burial Date thereof Jan. 21, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (Year)  
 Cemetery or crematory St. Stanislaus Cemetery  
 Location Boswell, Pennsylvania

18. Funeral director Jay O. Hay  
 Address 409 Main St., Boswell, Pa.

19. Jan. 17, 1946 Earl T. Webster  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1946 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 13, 1945 to January 17, 1946  
 and that I last saw her alive on January 17, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 5 Mos.

Due to Tubercle Bacilli

Due to \_\_\_\_\_

Other conditions Fatal Pulmonary Hemorrhage  
 (Include pregnancy within 3 months of death)

Major findings of operations No operation  
 Date of op. \_\_\_\_\_

Autopsy results No autopsy  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D.  
 Address Mount Wilson, Md. Date signed 1/17/46

Rec'd 1-19-46 Dr. S. E. Nichols

RECEIVED

JAN 19 1946

BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH  
County Baltimore  
City or town Relay  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 127 hrs  
Hospital, institution, or street address where death occurred:  
5007 Hazel ave  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Md County Baltimore  
City or town Relay  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5007 Hazel ave  
(If rural, give LOCATION)  
2. (a) If veteran, name war none

3. (a) FULL NAME Marie Emma Langschmidt 3. (b) Social Security Number none

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife Edward William Langschmidt 6. (c) if alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Mar 14 1891

8. AGE: Years 54 Months 9 Days 20 It less than one day hrs. min.

9. Birthplace Baltimore Md  
(Town, county, and state)

10. Usual occupation domestic

11. Industry or business Housewife

12. Name Horan

13. Birthplace Baltimore

14. Maiden name Annie R. Treason

15. Birthplace Baltimore Md

16. Informant Mr. E. W. Langschmidt

Address 5007 Hazel ave Relay Md

17. Burial Burial Date thereon 1/15/46  
(Burial, cremation, or removal, if none) (month) (day) (year)

Cemetery or crematory Louisa Park

Location Balto. Md.

16. Funeral director William Crok Inc.

Address 1217 St. Paul St.

19. 1/4 48 adk adk  
(Date rec'd by registrar) 19 Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1946 at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1945 to Jan 3 1946 and that I last saw her alive on Jan 2 1946

Immediate cause of death acute coronary occlusion, ad max DURATION 2da

Due to ch. myocarditis 15 mo  
met. influenza 13 mo

Due to influenza 7 wks

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations —

Autopsy results — Date of op. —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE A. B. Brumbaugh M. D. or other

Address 2207 Main St Elkridge Md Date signed 1/5/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00257 P

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 42

## 1. PLACE OF DEATH

County BaltimoreCity or town Arbutus  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yearsHospital, institution, or street address where death occurred: -How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltimoreCity or town Arbutus  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4408 Leeds Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Frank J. Law

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Sophia A. Law7. Birth date of deceased (mo., day, yr.) Sept 19th 18636. (c) If alive, give age 62 years8. AGE: Years 62 Months 4 Days 3 It less than one day - hrs. - min.9. Birthplace Baltimore, md  
(Town, county, and state)10. Usual occupation Tool - Shoe maker11. Industry or business Westington House E. B.12. Name Rev. Law13. Birthplace md14. Maiden name Margaret Leifer15. Birthplace md16. Informant Mrs Sophia A. LawAddress 4408 Leeds Ave17. Burial Date thereof Jan 25-46  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Landon ParkLocation Baltimore, md18. Funeral director F. A. Myerhoff, SonAddress 300 Canton Place19. Jan 24 1946 Registrar Ger Kipper

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 22nd 1946 at 3:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 35 to Jan 21 19 46and that I last saw him alive on Jan 21 19 46Immediate cause of death Pulmonary TuberculosisDURATION 3 yrs -

Due to

Due to

Other conditions menstruation - dehydration 5 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frederic V. Baxter M. D. or otherAddress 723 Lehigh Ave. Balt - Md Date signed 1-23-46

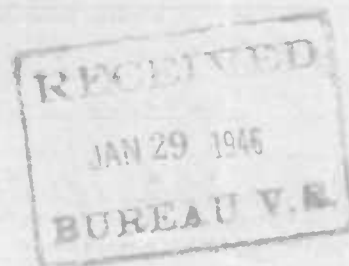
MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00258

*L. J. Bittler*



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County Balto.Village or City Villa NovaRegistration Dist. No. 32No. Essers Ave St.  Ward 

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 2 yrs.  mos.  ds. How long in U.S. if of foreign birth?  yrs.  mos.  ds.2. FULL NAME Ella Dobson Leithiser(a) Residence: No. 114 S. Washington St.  Ward 

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
-------------------------	----------------------------------	---

5a. If married, widowed or divorced  
HUSBAND of (or) WIFE of George S. Leithiser

6. DATE OF BIRTH (month, day, and year) Dec 9-1860

7. AGE	Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
	<u>85</u>	<u>1</u>	<u>15</u>	

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BDOCKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Havre de Grace Md  
(State or country)

13. NAME W. H. Dobson

14. BIRTHPLACE (city or town) Havre de Grace Md  
(State or country)

15. MAIDEN NAME Margaret Brown

16. BIRTHPLACE (city or town) Havre de Grace Md  
(State or country)

17. INFORMANT Dr. William Leithiser  
(Address) 84 Yorkway Dundalk Md

18. BURIAL, CREMATION, OR REMOVAL  
Place Angel Hill Cem Date Jan 27, 1946

19. UNDERTAKER Pennington & Son  
(Address) Havre de Grace Md

20. FILED 1-25-46 E. E. Nichols  
Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan 24th, 1946  
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Nov, 1944, to Jan 24, 1946

I last saw her alive on Jan 22, 1946; death is said

to have occurred on the date stated above, at 11:15 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:

Cerebral hemorrhage 1-12-46  
Arterio sclerosis ?  
Arterial hypertension ?

Other Contributory Causes of Importance:

Injured by heavy fall from fracture hip

Name of operation none Date of

What test confirmed diagnosis? clinical Was there an autopsy?

23. If death was due to external causes (VIDLENCE) fill in also the following:

Accident, suicide, or homicide?  Date of Injury , 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HDME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) E. E. Nichols M. D.

(Address) Baltimore Md



# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Bacon.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0026038

## 1. PLACE OF DEATH:

County ParkvilleCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

8007 Harford Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ParkvilleCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8007 Harford Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Edna H. Lewis

## 3.(b) Social Security Number

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife John E. Lewis

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 10, 1886 18878. AGE: Years 66 58 Months 7 Days 25 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation at home

11. Industry or business

12. Name Herman Kunning13. Birthplace Germany14. Maiden name Henrietta District15. Birthplace Germany16. Informant Mr. John E. LewisAddress 8007 Harford Road17. Burial Date thereof 1/8/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BaltimoreLocation Baltimore18. Funeral director Leonard J. RuckAddress 5305 Harford Road-14-19. 1/6 46 A. M. Bacon  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 5th, 19 46, at 1557 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 14 19 45 to Jan. 5 19 46  
and that I last saw him alive on January 4 19 46

Immediate cause of death

Carcinomatosis

DURATION

6 mosDue to Carcinoma of left breast1 yr +

Due to

Other conditions Pathological fracture,  
both thighs carcinoma  
(Include pregnancy within 8 months of death)6 mos +3 wks.Major findings of operations Carcinoma breast  
Date of op. Feb. 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. Bacon M. D. or otherAddress 2810 Taylor Ave. Date signed 1/6/46

RECEIVED  
JAN 7 1946  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 hr. 10 min.  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Fort Howard, Md.  
 How long in hospital or institution? 1 hr. 10 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1514 W. Baltimore St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW-II

## 3. (a) FULL NAME

JOHN C. LEWIS

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>Divorced</u>	
6. (b) Name of husband or wife _____			
6. (c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>September 18, 1898</u>			
8. AGE: Years <u>47</u>	Months <u>3</u>	Days <u>19</u>	If less than one day _____ hrs. _____ min.
9. Birthplace <u>Garfield, Ga.</u> (Town, county, and state)			
10. Usual occupation <u>Soldier</u>			
11. Industry or business _____			
FATHER	12. Name <u>Wm. Thomas Lewis</u>		
	13. Birthplace <u>Garfield, Ga.</u>		
MOTHER	14. Maiden name <u>Lavania Oglesby</u>		
	15. Birthplace <u>Garfield, Ga.</u>		

16. Informant Vets. Adm. Clinical Records  
 Address Fort Howard, Md.

17. Burial Date thereof Jan. 10 - 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Hebron Cemetery  
Garfield, Ga.  
 Location \_\_\_\_\_

18. Funeral director A. Lee Oder  
 Address 4644 York Rd. Balto. Md.

19. 1-8 19 46  
 (Date rec'd by registrar) Registrar AW Medsich

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 19 46 at 2:10A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 19 46 to January 6 19 46  
 and that I last saw him alive on January 6, 1946 19 \_\_\_\_\_

Immediate cause of death Acute Coronary Occlusion  
 DURATION unknown

Other conditions Hemorrhagic Pancreatitis;  
Toxic Hepatitis; Alcoholism acute;  
Terminal Bronchopneumonia  
 (Include pregnancy within 8 months of death)  
 Major findings of operations \_\_\_\_\_

Due to \_\_\_\_\_

Date of op. \_\_\_\_\_  
 Autopsy results same as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE MB Davis M.D.  
Asst. Sup. Med. Exam. M. D. or other  
 Address Vets. Adm. Fort Howard, Md. Date signed 1-6-46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 222

00262

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death? 14 mos.

Hospital, institution, or street address where death occurred:

Robbs Nursing HomeNow long in hospital or institution? 14 Mos.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Pylesville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Flora Lowe

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

WidowedB.(b) Name of husband or wife John F. Lowe

B.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) March 15, 1880

8. AGE: Years

65

Months

9

Days

17

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Home duties

11. Industry or business

12. Name Elijah E. Nichols13. Birthplace Maryland14. Maiden name Mariah J. Mitchell15. Birthplace Delaware18. Informant Dr. E. E. NicholsAddress Pikesville-3, Md.17. Burial Date thereof 1 - 14 - 46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Friends Cem.Location Fawn Grove, Pa.18. Funeral director Howard WebbAddress Fawn Grove, Pa.19. 1 - 12 - 46 E. E. Nichols

(Date rec'd by registrar) \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH Jan. 12, 46 at 6:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 15, 1942 to Jan. 12, 1946and that I last saw him/her alive on Jan. 11, 1946

Immediate cause of death

Cerebral hemorrhage

DURATION

Oct. 151942Due to Arterio SclerosisDue to Arterial hypertensionOther conditions Heart failure(Invalid for 3 yrs. 3 mos.)

(Include pregnancy within 3 months of death)

few days

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. E. Nichols M.D.

M. D. or other

Address Pikesville-3, Md.Date signed 1/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 14 1946  
BUREAU V. E.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

00263

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Balto.City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

628 Eastern Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Essex  
(If outside city or town limits, write RURAL and give nearest town)Street No. 628 Eastern Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Louise Lynch

## 3. (b) Social Security Number

4. Sex F. 5. Color or race W 6. (a) Single, married, widowed, or divorcedWidowed6. (b) Name of husband or wife Joseph B. Lynch7. Birth date of deceased (mo., day, yr.) 10-23-1873 8. (c) If alive, give age years8. AGE: Years 72 Months 2 Days 23 If less than one day  
hrs. min.9. Birthplace Balto Co. Md.  
(Town, county, and state)10. Usual occupation at home11. Industry or business at home12. Name Charles Miller13. Birthplace Md.14. Maiden name Unknown15. Birthplace "16. Informant William G. BowerAddress Same17. Burial Date thereof 1-19-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Moulton ParkLocation Taylor Ave.18. Funeral director John G. ConnellyAddress 418 Eastern Ave. Essex, Md.19. 1/19/46 John G. Connelly  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 19 46 at 9 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 45 to Jan 16 19 46and that I last saw him alive on Jan 16 19 46Immediate cause of death Acute Coronary ArteriosclerosisDue to arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE L. Mary H. HummelAddress 417 1/2 Eastern Ave. Date signed Aug 14, 1946

M. D. or other

RECEIVED  
JAN 24 1946  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

00264

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Ft. Howard, Md.  
 How long in hospital or institution? 15 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3629 Belvedere Avenue  
 (If rural, give LOCATION)  
 2(a) If veteran, name war SAW

## 3. (a) FULL NAME

GEORGE W. LYTTLE

## 3. (b) Social Security Number

212-07-4986

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mrs. Gertrude Lyttle  
 6. (c) If alive, give age 70 years  
 7. Birth date of deceased (mo., day, yr.) 9-29-75  
 8. AGE: Years 70 Months 3 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business \_\_\_\_\_  
 12. Name George Lyttle  
 13. Birthplace Baltimore, Md.  
 14. Maiden name Elenore Fifer  
 15. Birthplace Baltimore, Md.

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Ft. Howard, Md.

17. Burial Date thereof 1/28/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Loudon Park Cem.  
 Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS  
 Address Balto., Md.

19. Jan 26 19 46 Awkard  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 24, 19 46 at 1.15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9, 1946 19 46 to January 24, 19 46 and that I last saw him alive on January 24, 19 46

Immediate cause of death Carcinoma of stomach DURATION 6 Mos.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Amr Balter A. M. BALTER, LT. COL., M. D. or other \_\_\_\_\_

Address Ft. Howard, Maryland Date signed 1-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of  
birth date of deceased &  
age is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 75-4

00265

FILM No. I O O FEB 26 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Balto

City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

521 Dorsey Ave.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 521 Dorsey Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

William P Mackey

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced widowed

B.(b) Name of husband or wife Mary Keane

7. Birth date of deceased (mo., day, yr.) April 16, 1869 6.(c) If alive, give age years

8. AGE: Years 76 Months Days If less than one day hrs. min.

9. Birthplace Ireland  
(Town, county, and state)

10. Usual occupation Retired

### 11. Industry or business

12. Name John Mackey

13. Birthplace Ireland

14. Maiden name Mary Burke

15. Birthplace Ireland

18. Informant Maurice Mackey

Address

11. Burial Date thereof 1/28/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Sacred Heart

Location German Hill Rd.

18. Funeral director John V. Connelly

Address 418 Eastern Ave. Essex 21

19. 1-28- 19 46 phon G. Connelly  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25- 19 46 at 12:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1899-1st 19 45 January 25- 19 46

and that I last saw him alive on January 25- 19 46

Immediate cause of death

Chronic Myocarditis

Due to

Due to

Other conditions no

(Include pregnancy within 8 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. White M.D. M. D. or other

Address 7601 Eastern Ave Date signed 1/28/46

Balto 24, Md

RECEIVED  
JAN 28 1946  
BUREAU V.E.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH (148)

Registered No.

P 38

00200

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: *Hillen Rd. at Stevenson*(c) Hospital or institution: *Lane, Towson*(d) Length of stay in hospital or inst. (yrs., mos., or days) *1 yr.*

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Balto.*(c) City or town *Towson*  
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)  
If yes, name country

## 3 (a) FULL NAME

*Arthur Alvin Martin*

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

*Male*

5. Color or race

*Colored*

6 (a) Single, married, widowed, or divorced.

*Single*

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *June 12, 1903*8. AGE: Years *42* Months Days If less than one day  
hr. min.9. Birthplace *Richmond, Va.*  
(Town, county, and state)10. Usual Occupation *Laborer*

11. Industry or business

12. Name *John L. Martin*13. Birthplace *Va.*14. Maiden Name *Mary Winston*15. Birthplace *Va.*16 (a) Informant *Richard Martin*(b) Address *530 Greene Ave Brooklyn, NY*17 (a) *Burial* (b) Date thereof *1-7-46*

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Mt. Calvary*Location *Anne Arundel County*18 (a) Funeral director *Byron & Mamie Wright*(b) Address *721 Ringgold St.*19 (a) *1-7-46* (b) *A W Hedrick*

(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *January 1, 1946* at *7 A* M

21. I certify that I took charge of the remains described above, held an

*Autopsy* thereon and from the evidence obtained  
Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to *his* death on the day stated above, and death in myopinion resulted from: natural causes ☐, accident ☐, suicide ☐,homicide ☒, undetermined ☐ and that the causes of death were:IMMEDIATE CAUSE OF DEATH *Fracture of skull*

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:(a) Date of injury *Found 1-1-46* at *A.* M.(b) Where did injury occur? *Found: Hillen Rd. at**Stevenson Lane, Towson*

(c) Did injury occur at home, on farm, industrial place, in public

place? *Public* While at work? *No*(d) Means of injury *Blunt force*23. Signature *R. A. E. Graham* M.D.Date signed *Jan 2 1946* Medical Examiner.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1372

## CERTIFICATE OF DEATH

Reg. Dist. No. 00267 34

## 1. PLACE OF DEATH

County BaltimoreCity or town New Albawstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town New Albawstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Luther E Martin

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Sarah E Martin7. Birth date of deceased (mo., day, yr.) May 22 - 1871

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 74 Months 7 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Farmers

11. Industry or business

12. Name Caleb M Martin13. Birthplace MD14. Maiden name Eunice Keup15. Birthplace MD16. Informant Richard Martin

Address

Hampstead MD17. Burial Date thereof Jan 21/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory GraveLocation Balto Co MD18. Funeral director Edw E TiptonAddress Hampstead MD19. Jan 19 1946 April E. Fowle MD  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18, 1946, 3:30 P. M.21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Oct. 30, 1945, to Jan. 18, 1946, and that I last saw him alive on Jan. 18, 1946.Immediate cause of death Chronic Myocarditis DURATION Unknown  
Cor. Sclerotic Cordis  
Vascular Rense  
Due to Disease.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. E. Bush M.D.Hampstead MD Date signed 1/19/46

RECEIVED

JAN 22 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00268

Reg. Dist. No. 35

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Rural near Freeland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 87 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Rural near Freeland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5 mi. West of Freeland  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.

## 3. (a) FULL NAME

James Wesley Masemore.

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife Alice M. Smith.7. Birth date of deceased (mo., day, yr.) Sept. 18, 1858. 6. (c) If alive, give age years8. AGE: Years Months Days If less than one day  
87 3 18 hrs. min.9. Birthplace Freeland, Md. R.D.  
(Town, county, and state)10. Usual occupation Retired Farmer11. Industry or business Own Farm.12. Name Unknown.13. Birthplace LI14. Maiden name Unknown.

15. Birthplace

16. Informant Mrs. Ida BakerAddress New Freedom, Pa. R.D.17. Burial Date thereof January 9, 1946.  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Iltz Cemetery.Location Glen Rock, Pa. R.D.18. Funeral director John J. BartonsAddress New Freedom, Pa.19. Jan 7 1946 John J. Bartons  
(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1946 at 6:05 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 1945 to Jan 6 1946 and that I last saw him alive on Jan. 5 1946.

Immediate cause of death

DURATION

Cerebral HemorrhageDue to arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. L. Eagle

M. D. or other

Address New Freedom, Pa. Date signed 1/7-46

RECEIVED

FEB 3 1946

BUREAU V.S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 40

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland *Found in a swamp at Pottersburg*  
 (b) Street address.....  
 (c) Hospital or institution: *Balto. Co. Md.*

*June 29, 1946*  
*Missing since Nov. 18 - 1945*  
 (d) Length of stay in hospital or inst. (yrs., mos., or days)  
 (e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Baltimore*  
 (c) City or town *Baltimore*  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. *3100 Royston Ave*  
 (If rural give location)  
 (e) Citizen of foreign country? *no* (Yes or No)  
 If yes, name country.....

## 3 (a) FULL NAME

*Anthony Mastrocola*3 (b) If veteran, name war  
*no*3 (c) Social Security Account  
No.

4. Sex *male* 5. Color or race *white* 6 (a) Single, married, widowed, or divorced. *Widowed*

6 (b) Name of husband or wife *late Emanuela*  
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *June 18 1869*

8. AGE: Years *76* Months *7* Days *11* If less than one day  
 hr. min.

9. Birthplace *Italy*  
 (Town, county, and state)

10. Usual Occupation *Stone mason*

11. Industry or business

FATHER 12. Name *Nicola M. Mastrocola*13. Birthplace *Italy*MOTHER 14. Maiden Name *Maria M. Gabriela*15. Birthplace *Italy*16 (a) Informant *Mrs. Ubert Jockisch (daughter)*(b) Address *2700 Maple Ave (Parkville Md)*

17 (a) *Burial* (b) Date thereof *2/4-1946*  
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Holy Redeemer*  
 Location *Belair Rd.*

18 (a) Funeral director *Frank Pella, Voice*(b) Address *52 N. Mallow St*

19 (a) *2-4-46* (b) *awmed*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan. 29* 19*46*, at *11 P.* M

21. I certify that I took charge of the remains described above, held an *Autopsy, Inspection or Inquiry* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☒ and that the causes of death were:

## IMMEDIATE CAUSE OF DEATH

*Impossible to determine*

Due to.....

Other Condition *Small amount of decomposed tissues on facial skeleton.*  
 (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... at..... M.  
 (b) Where did injury occur?  
 (c) Did injury occur at home, on farm, industrial place, in public place? While at work?  
 (d) Means of injury.....

23. Signature *Howard J. Gualberto* M.D.  
 Date signed *2-1-46* Medical Examiner.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00270

Reg. Dist. No.

38

### 1. PLACE OF DEATH:

County BALTIMORE  
City or town TOWSON  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 year; 11 months; 24 days  
Hospital, institution, or street address where death occurred:  
THE SHEPPARD AND ENOCH PRATT HOSPITAL  
How long in hospital or institution? 1 year; 11 months; 24 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Sparks  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

MATTHEWS, THOMAS OLIVER

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife 1. Mary Louise Matthews  
2. Clara E. Matthews  
Both deceased 8.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) February 12, 1855

8. AGE: Years 90 Months 11 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cockeysville, Balto. Co., Md.  
(Town, county, and state)

10. Usual occupation Employment office for farm workers

### 11. Industry or business

12. Name Thomas Hopkins Matthews

13. Birthplace Baltimore County, Md.

14. Maiden name Elizabeth Ann Price

15. Birthplace Baltimore County, Md.

16. Informant HOSPITAL RECORDS

Address \_\_\_\_\_

17. Burial Date thereof Jan 17, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Friends

Location Sparks Maryland

18. Funeral director Sander m. Brook

Address Sparks, Md.

19. Jan 16 19 46 Sparks, Md.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 19 46 at 3:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21 19 44 to January 15 19 46  
and that I last saw him alive on January 15 19 46

Immediate cause of death Chronic  
myocarditis and  
myocardial degeneration 20 yrs.  
Due to coronary arter-  
sclerosis 20 yrs.  
Due to \_\_\_\_\_

Other conditions generalised arteri-  
sclerosis. Old fracture  
right femur within 3 months of death  
Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_  
Autopsy results confirmation of above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. W. ELGIN M. D. or other \_\_\_\_\_  
Address TOWSON, MD. Date signed Jan 15, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MAINTAIN STATE OF HEALTH

CERTIFICATE OF DEATH

DECEASED

DECEASED

DECEASED

RECEIVED  
FEB 3 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 193

## CERTIFICATE OF DEATH

00271

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1907 Hillside Drive

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1907 Hillside Drive  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Arthur R. McGinnis

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
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6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) January 25, 1935

8. AGE:	Years	Months	Days	If less than one day
	<u>10</u>	<u>11</u>	<u>13</u>	_____ hrs. _____ min.

9. Birthplace Woodlawn, Md.  
(Town, county, and state)10. Usual occupation School Boy

## 11. Industry or business

12. Name William G. McGinnis, Sr.13. Birthplace Baltimore, Md.14. Maiden name Martha Ellen Sakers15. Birthplace Baltimore, Md.16. Informant Mr. William G. McGinnis, Jr.Address 1907 Hillside Drive, Woodlawn17. Burial Date thereof Jan. 11, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Olive CemeteryLocation Randallstown, Md.18. Funeral director Miller's LamonianAddress 4510 Liberty Heights Ave.19. Jan. 11 19 46 A. H. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH January 8 19 46 at 6.20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Shock DURATIONDeep to wounded wireDue to home electric currentBad wireDue to accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Jan 8, 46Where did injury occur? Woodlawn (City or town) Baltimore (County) Md. (State)Injured at home, farm, industry, public place (where?) homeMeans of injury wounded wire Injured at work? no23. SIGNATURE Geo. S. Lippert Edna H. Ball  
1010 Leeds Ave. M. D. or otherAddress Arbutus, Md. Date signed 1-9-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *RD*

## CERTIFICATE OF DEATH

00272 *P*Reg. Dist. No. *30*

1. PLACE OF DEATH: *Salto*  
 County.....  
 City or town..... *Catonsville*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
*62 N. Prospect Ave.*  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
*Md.*  
 State..... County.....  
 City or town..... *Catonsville*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *62 N. Prospect Ave.*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
*LAURA SUSAN MERRICK*

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*  
 6.(b) Name of husband or wife..... *George R. Merrick*  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) *April 27, 1865*  
 8. AGE: Years *80* Months *9* Days *0* If less than one day  
 .....hrs. ....min.

9. Birthplace *Carroll Co., Md.*  
 (Town, county, and state)  
 10. Usual occupation..... *Housewife*  
 11. Industry or business

FATHER 12. Name *Amos Little*  
 13. Birthplace *Carroll Co., Md.*  
 MOTHER 14. Maiden name..... *Ellen Lovell*  
 15. Birthplace *Carroll Co., Md.*

16. Informant *Mrs. Jennie Barrack*  
 Address *1504 Moreland Ave.*

17. Burial Date thereof..... *1/30/46*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... *Meadow Branch*  
 Location..... *Carroll Co., Md.*

18. Funeral director..... *WM. J. TICKNER & SONS*  
 Address *Balto., Md.*

19. *1/29 46*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *January 27* 19*46*, at *12:05 A.M.*  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*July 15* 19*40*, to *January 27* 19*46*  
 and that I last saw him..... alive on *January 26* 19*46*

Immediate cause of death.....  
*Broncho-Pneumonia*

Due to *Chronic Cardio-Vascular Disease*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury Injured at work?

23. SIGNATURE *William K. Gallagher M.D.*  
*Catonsville, Md.* M. D. or other

Address..... Date signed *1-28-46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00273

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Mount Wilson  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 0 yrs., 1 mo., 15 daysHospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis SanatoriumHow long in hospital or institution? 0 yrs., 1 mos., 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore, Maryland  
(If outside city or town limits, write RURAL and give nearest town)Street No. Y.M.C.A., 24 W. Franklin Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Mr. George Merritt

## 3.(b) Social Security Number

Yes, # Unknown.

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife

6.(c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

February 21, 1899

## 8. AGE:

Years

Months

Days

If less than one day

461111

\_\_\_\_\_ hrs.

\_\_\_\_\_ min.

## 9. Birthplace

Philadelphia, Pa.

(Town, county, and state)

## 10. Usual occupation

Salesman

## 11. Industry or business

FATHER

## 12. Name

George F. Merritt

## 13. Birthplace

Buffalo, New York

MOTHER

## 14. Maiden name

Jennie J. James

## 15. Birthplace

Philadelphia, Pa.

## 16. Informant

George Merritt

## Address

Y.M.C.A., 24 W. Franklin St., Balto

## 17.

Cremation

(Burial, cremation, or removal. Which?)

Date thereof

1/1/46

(month) (day) (year)

## Cemetery or crematory

Chelton Hills Crematory

## Location

Chelton Hills, Pa.

## 18. Funeral director

Hackman Bros.

## Address

905 Lehigh St., Phila., Pa.

## 19.

Jan. 1,19 46

(Date rec'd by registrar)

Earl T. Webster

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH January 1, 19 46, at 11:20 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 17, 19 45, to Jan. 1, 19 46and that I last saw him alive on January 1, 19 46

## Immediate cause of death

Pulmonary Tuberculosis

## DURATION

2 Yrs.

Due to

Tubercle BacilliDiabetes MellitusUnknown

Due to

Tuberculous Laryngitis9 Mos.

Other conditions

Fatal Pulmonary Hem-orrhage

(Include pregnancy within 3 months of death)

## Major findings of operations

No operation

Date of op. \_\_\_\_\_

## Autopsy results

No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Stewart S. Shaffer M.D.

M.D. or other

Address

Mt. Wilson, Md.

Date signed

1/1/46

RECEIVED  
JAN 7 1946  
BUREAU V.A.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

00274

P

## 1. PLACE OF DEATH

County

Balto.

Village or City

Sparrows Point.

No.

Slang Mill #Cook St. East Ward

Registration Dist. No.

44

Length of residence in city or town where death occurred

48

yrs.

mos.

ds.

How long in U.S. if of foreign birth?

yrs.

mos.

ds.

## 2. FULL NAME

Russell Merritt

(a) Residence: No.

Railway Ave Dundalk Md.

(Usual place of abode)

St.

Wards

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

ANANA M. MERRITT

6. DATE OF BIRTH (month, day, and year)

SEPT. 17

1897

7. AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

48

3

15

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER SAWYER, BOOKKEEPER, etc.

CAR INSPECTOR

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

SPARROWS POINT

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)

BALTIMORE MD.

(State or country)

FATHER

13. NAME

WILLIAM H. MERRITT

14. BIRTHPLACE (city or town)

BALTO. MD.

(State or country)

MOTHER

15. MAIDEN NAME

FLORENCE GRITSCH

16. BIRTHPLACE (city or town)

PENNA.

(State or country)

17. INFORMANT

ANNA MERRITT (WIFE)

(Address)

6704 RAILWAY AVE. DUNDALK MD.

18. BURIAL, CREMATION, OR REMOVAL

Place

OAK LAWN

Date

JAN. 5

19. 46

19. UNDERTAKER

Lilly &amp; Zeider inc.

(Address)

403 S. WOLFE ST.

20. FILED

1-4

19

46

Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

(Month)

(Day)

(Year)

Jan 1 1946

22.

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1946, to

I last saw him alive on

to have occurred on the date stated above, at

The PRINCIPAL CAUSE OF DEATH and related causes of Importance were as follows:

Compound multiple fracture both lower limbs + left arm (Crushed)

Date of onset

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide

Where did injury occur?

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Industry

Manner of injury

Nature of injury

Run over by freight train

R.R. accident

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)



# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

**Example II**

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Baltimore  
City or town Cockeysville Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 1/2 yrs  
Hospital, institution, or street address where death occurred Spasoria Home, Cockeysville Md.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County   
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 576 N. Monroe St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mrs. Annie Middlemore

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

B.(b) Name of husband or wife Samuel S. Middlemore

7. Birth date of deceased (mo., day, yr.) Oct 22 - 1858 6.(c) If alive, give age  years

8. AGE: Years 87 Months 3 Days 8 If less than one day  hrs.  min.

9. Birthplace Dayton Ohio.  
(Town, county, and state)

10. Usual occupation Housewife

### 11. Industry or business

12. Name William Rolfe

13. Birthplace London Eng.

14. Maiden name Lorina Threl

15. Birthplace London Eng.

16. Informant Laura M. Schoder

Address Spasoria Home, Cockeysville Md.

17. Burial Date thereof Feb 2 - 46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Lorraine Cemetery

Location Baltimore Md.

18. Funeral director Geo L. Bueh Jr.

Address 1512 Hollins St.

19. Jan 30 - 19 46 L.M. Schoder  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 19 46, at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 39 to Jan 30 19 46  
and that I last saw him alive on Jan 30 19 46

Immediate cause of death Cardiac DeCompensation DURATION 3 weeks

Due to Uremia 4 days

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur?  (City or town) (County) (State)

injured at home, farm, industry, public place (where?)

Means of Injury  Injured at work?

23. SIGNATURE Salomon Sherman M.D.

Address 2424 E. Tow Place Date signed 1/30/46

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 1 1946  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

00278

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 days

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD..... County..... BaltimoreCity or town..... Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7980 Hayford Road

(If rural, give LOCATION)

2.(a) If veteran, name War.....

## 3. (a) FULL NAME

Adolph Milauskas

## 3. (b) Social Security Number

4. Sex.....

male

5. Color or race.....

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife..... Bathervie A.

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Feb 12, 18878. AGE: Years..... 58 Months..... 11 Days..... 25 If less than one day..... hrs. .... min.9. Birthplace..... Lithuania

(Town, county, and state)

10. Usual occupation..... Tailor

11. Industry or business.....

12. Name..... Nicholas Milauskas13. Birthplace..... Lithuania14. Maiden name..... Constance Glimski15. Birthplace..... Lithuania16. Informant..... Mrs Bathervie A. MilauskasAddress..... 7980 Hayford Rd. Parkville, Md.17. Funeral Date thereof..... 1/30/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Holy Redeemer CemLocation..... 4430 Blair Road18. Funeral director..... St. BonaventureAddress..... 901-03 Hallway St19. 1/28 19 46 Adolph Milauskas

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 27, 1946 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/27 19 46 to 1/27 19 46and that I last saw him alive on 1/27 19 46

Immediate cause of death.....

Coronary thrombosis

DURATION

1 day

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... H. A. Grott, M.D.

M. D. or other

Address..... 8100 Hayford Rd. Date signed..... 1/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-8

## CERTIFICATE OF DEATH

Reg. Diat. No. 31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6819 Windsor Mill Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Lizzie Abbott Milburn

## 3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife John Henry Milburn7. Birth date of deceased (mo., day, yr.) December 3, 1870

8. AGE: Years Months Days If less than one day

75112

.....hrs. ....min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name J. H. Brunker13. Birthplace Talbot Co. Md.14. Maiden name Indiana T. Grant15. Birthplace Charlestown, Md.16. Informant Mr. John H. MilburnAddress 6819 Windsor Mill Road17. Burial Date thereof Jan 18, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lorraine ParkLocation Woodlawn, Balto. Co. Md.18. Funeral director Wm. J. Tickner & Sons, Inc.Address North & Pa. Aves. Balto. Md.19. 1-17 46

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 15, 1946, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 12, 1945 to Jan. 15, 1946and that I last saw him alive on Jan. 15, 1946

Immediate cause of death

Carcinoma of stomachand metastasis to liver

Due to

Due to Carcinoma of stomach

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles D. WrightAddress 2220 Garrison Blvd.Date signed 1/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00278

## CERTIFICATE OF DEATH

Reg. Dist. No.

33-

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Parkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 42 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Parkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Main St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

John Wesley Miller

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Louella Carr  
 7. Birth date of deceased (mo., day, yr.) July 15, 1903 6. (c) If alive, give age 40 years  
 8. AGE: Years 42 Months 5 Days 28 If less than one day  
 hrs. min.

9. Birthplace Parkton, Md. R.D.  
 (Town, county, and state)  
 10. Usual occupation Watchman  
 11. Industry or business Railroad  
 12. Name John Wesley Miller  
 13. Birthplace Balto., Co. Md.  
 14. Maiden name Edith Wilson  
 15. Birthplace Balto. Co., Md.

16. Informant Mrs. Louella Miller  
 Address Parkton, Md.  
 17. Burial Date thereof Jan. 17, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory New Market Cem.  
 Location Maryland Line, Md.  
 18. Funeral director Joseph Hartenstein  
 Address New Freedom, Pa.

19. Jan 13 1946 John E. Miller Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1946, at 12:45 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 1946 to Jan 13 1946  
 and that I last saw him alive on Jan 16 1946

Immediate cause of death Chronic myocarditis  
 Due to  
 Due to  
 Other conditions Bronchial asthma  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE J. M. France M. D. or other  
Parkton, Md. Address Date signed 1/13/46



RECEIVED  
FEB 3 1946  
BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 years, 2 months, 4 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 6 years, 2 months, 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Jewish Shelter House, Asquith St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war..... -

## 3. (a) FULL NAME

Jack Moskowitz

## 3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... divorced  
 6. (b) Name of husband or wife..... Bella Lipkovits  
 6. (c) If alive, give age..... ? years  
 7. Birth date of deceased (mo., day, yr.) April 10, 1889  
 8. AGE: Years..... 56 Months..... 9 Days..... 7 If less than one day..... hrs. .... min.

9. Birthplace..... Ungvar, Hungary  
 (Town, county, and state)  
 10. Usual occupation..... unemployed  
 11. Industry or business.....

FATHER  
 12. Name..... David Moskowitz  
 13. Birthplace..... Hungary  
 MOTHER  
 14. Maiden name..... Leni Roth  
 15. Birthplace..... Hungary

16. Informant..... Hospital Records  
 Address..... Catonsville-28, Md.

17. Burial Date thereof..... Jan 18-46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory..... Sheb Shalom  
 Location..... Herman Hill Park  
Jack Lewis Inc

18. Funeral director.....  
 Address..... 1439 E 13th St

19. 1-18 46  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 17 19. 46 at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
November 13 19. 39 to January 17 19. 46  
 and that I last saw him alive on January 17 19. 46

Immediate cause of death..... Tabo Paresis DURATION  
Indef.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results..... no.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... Dr. Jack Lewis  
Catonsville-28, Md.

M. D. or other

Address..... Date signed 1/17/46

RECEIVED  
JAN 19 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00280

★ Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 years

Hospital, institution, or street address where death occurred:

202 W. Penna. Ave.How long in hospital or institution? ---

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. 202 W. Penna. Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war ---

## 3. (a) FULL NAME

ANNA MARY NEIDHARDT

## 3. (b) Social Security Number

\*\*\*\*\*

## 4. Sex

Female

## 5. Color or race

White

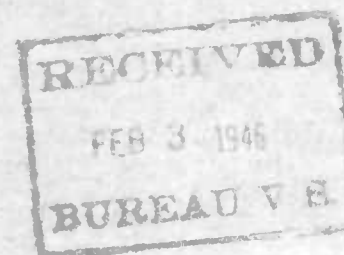
## 6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife J. William Neidhardt6. (c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) June 4, 18738. AGE: Years 72 Months 7 Days 18 If less than one day  
.....hrs. ....min.9. Birthplace St. Mary's, Penna.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home12. Name John A. Blatta13. Birthplace Baltimore, Maryland14. Maiden name Julia A. Biokelmenn15. Birthplace Wellsburg, W. Va.16. Informant Mr. J. William NeidhardtAddress 202 W. Penna. Ave., Towson, Md.17. Burial Date thereof Jan. 24, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. John's Catholic Cem.Location Frederick, Maryland18. Funeral director John Burns' SonsAddress Towson, Maryland19. Jan 23 46 John A. Blatta  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 46 3:43P.  
19.....at.....21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Sept 12 44 to Jan 22 46  
and that I last saw him/her alive on Jan 21 46Immediate cause of death Myocarditis DURATION IndefiniteDue to Generalized arteriosclerosis IndefiniteDue to -----Due to -----Other conditions Hemiplegia - complete 18 mos.  
Right side  
(Include pregnancy within 3 months of death)Major findings of operations ----- Date of op. -----Autopsy results -----  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide ----- Date of -----Where did injury occur? ----- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE Nathaniel M. Beck MD M. D. or otherAddress 2727 N. Charles St. Date signed Jan 23-46



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Evidence for change of age is

shown on

PLACE OF BIRTH 1 1946

## STATE OF MARYLAND—CERTIFICATE OF DEATH

002810

County Balto.Village or City Dundalk.Registration Dist. No. 41No. 210 Potapscow Ave. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.2. FULL NAME Isabella Ness(a) Residence: No. 210 Potapscow Ave. St. Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

Jacob R.

6. DATE OF BIRTH (month, day, and year)

April 20 / 1854

7. AGE

Years

Months

Days

If LESS than

91-92812

1 day or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

at home

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

Hooper

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

York Co., Pa.

FATHER

13. NAME

Michael Ilges.

14. BIRTHPLACE (city or town) (State or country)

Pa.

MOTHER

15. MAIDEN NAME

Annie Barbara

16. BIRTHPLACE (city or town) (State or country)

Pa. Bar Harbor

17. INFORMANT (Address)

Mrs. Ann Marie Ness  
210 Potapscow

18. BURIAL, CREMATION, OR REMOVAL

Place Poplar Grove Date Jan 04, 1945

19. UNDERTAKER (Address)

Ulrich Funeral Home  
2008 Orleans St.

20. FILED

114, 1946 Am Heart

Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Jan 2, 1946, (Month) (Day) (Year)

22.

I HEREBY CERTIFY, That I attended deceased from

Dec 27, 1945 to Jan 2, 1946I last saw him alive on Dec 31, 1945; death is saidto have occurred on the date stated above, et. 11:30 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Myocardial Infarction

Date of onset

7 days

Other Contributory Causes of Importance:

Cardiovascular  
Renal Disease10 yrs.

Name of operation

none

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

Wm. C. ...

M. D.

(Address) Dundalk, Md.



# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

## Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

00285

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years, 1 mo., 7 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 10 years, 1 mo., 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 708 North Fulton Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Frances O'Ferrall

(O'FERRALL)

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced single  
 8.(b) Name of husband or wife \_\_\_\_\_  
 8.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) June, 1878  
 8. AGE: Years 67 Months 7 Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore  
 (Town, county, and state)  
 10. Usual occupation Saleslady  
 11. Industry or business Selling  
 12. Name Hugh O. Ferrall  
 13. Birthplace Ireland  
 14. Maiden name Annie Street  
 15. Birthplace Harford County, Md.

16. Informant Hospital records  
 Address Catonsville, -28, Md.

17. Burial London Park Date thereof 1/19/46  
 (Burial, cremation, or removal of body) (month) (day) (year)  
 Cemetery or crematory Balto. Md  
 Location William Cook Inc.

18. Funeral director William Cook Inc.  
 Address 1217 St. Paul St.

19. Jan 19 46 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 19 46 at 1:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 11 1935 to January 18 1946  
 and that I last saw him alive on January 18 1946

Immediate cause of death Chronic myocarditis DURATION 3 years

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Isadore Turk  
Isadore Turk, M.D. M. D. or other  
 Address Catonsville-28, Md. Date signed 1/18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

00282

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 22 years, 6 months  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution?..... 22 years, 6 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Harford  
 City or town..... Havre de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war.....

## 3. (a) FULL NAME

George Howard Osborn

## 3. (b) Social Security Number

4. Sex..... male  
 5. Color or race..... white  
 6.(a) Single, married, widowed, or divorced..... single  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... June 1876  
 8. AGE: Years..... 69 Months..... 6 Days.....  
 If less than one day..... hrs. .... min.

9. Birthplace..... Havre de Grace, Maryland  
 (Town, county, and state)  
 10. Usual occupation..... blacksmith  
 11. Industry or business..... blacksmith  
 12. Name..... Robert A. Osborn  
 13. Birthplace..... Maryland  
 14. Maiden name..... ?  
 15. Birthplace..... Mercy Silver, Maryland  
 16. Informant..... Hospital records  
 Address..... Catonsville-28, Md.

17. Burial Date thereof..... Jan. 11, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Harmony Cem.  
 Location..... Harford Co., Md.  
 18. Funeral director..... H. B. Bailey  
 Address..... Darlington, Md.  
 19. 1-10-46 19 46 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 9 19 46 6:10 p. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 30, 1 19 23 to January 9 19 46  
 and that I last saw him alive on January 9 19 46  
 Immediate cause of death.....  
Broncho pneumonia  
 Due to..... Myocardial insufficiency  
 Due to.....  
 Other conditions..... Mild diabetes  
 (Include pregnancy within 8 months of death)

## DURATION

2 daysunk.unk.

Major findings of operations.....  
 Date of op.....  
 Autopsy results..... none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... Isadore Turk  
Isadore Turk, M.D. M. D. or other  
 Address..... Catonsville-28, Md. Date signed..... 1/10/46

RECEIVED

JAN 14 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

## CERTIFICATE OF DEATH

Reg. Dist. No. 00283 44

## 1. PLACE OF DEATH

County..... Baltimore ..  
 City or town..... Sparks Park ..  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 6 years ..  
 Hospital, institution, or street address where death occurred:  
3104. Lynch Rd.  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....  
 City or town..... As in #1 ..  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mary Louise Owens

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Charles Louis Owens

7. Birth date of

deceased (mo., day, yr.) October 6, 1863

8. AGE:

Years 82 Months 2 Days 29 If less than one day

9. Birthplace

Gates Co. N. C.  
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

own home

12. Name

John Morris

13. Birthplace

Gates Co. N. C.

14. Maiden name

Harriet Ward

15. Birthplace

Gates Co. N. C.

16. Informant

Carl Owens

Address

Address as in #1

17. Burial

Burial Date thereof 11/7/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Mourlands Memorial

Location

Taylor Ave.

18. Funeral director

John J. Connelly

Address

418 Eastern Ave. Essex 21

19. 1/4/46

19. 46

John J. Connelly

Registral

Address

Balto 19 md

Date signed

1/4/46

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1946 at 9:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 12, 1934 to Jan. 4, 1946and that I last saw him alive on Jan. 4, 1946Immediate cause of death Basilar carcinomaDURATION 4 1/2 mo.Due to followed by intestinal hemorrhageDue to associated withOther conditions hypertensive cardio-vascular disease

12 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Louis M. Teller, M.D.

6908 N. Cr. Rd. M. D. or other

Address Balto 19 md Date signed 1/4/46

RECEIVED  
JAN 8 1946  
BUREAU V.E.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

00284

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH

County BaltimoreCity or town Rockdale  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 1/2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mrs. Florence Goldie Palmer

## 3. (b) Social Security Number

4. Sex

Female

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Willard Durham Palmer

7. Birth date of deceased (mo., day, yr.)

March 22-1890

6. (c) If alive, give age years

8. AGE:

Years 55 Months 9 Days 17 If less than one day

9. Birthplace

W. Washington Maryland  
(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

FATHER

12. Name

James Leach

13. Birthplace

Maryland

MOTHER

14. Maiden name

Martha Sprinkle

15. Birthplace

Maryland

16. Informant

Willard D. Palmer

Address

Mayfield Ave. Rockdale, Md.

17. (Burial, cremation, or removal. Which?)

Burial

Cemetery or crematory

Mount Olive

Location

Randallstown, Maryland

18. Funeral director

Murree Funeral Home

Address

3631 Falls Road, Baltimore

19. (Date rec'd by registrar)

1-11-46Dr. E. E. NicholsMD Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Rockdale  
(If outside city or town limits, write RURAL and give nearest town)Street No. Mayfield Avenue  
(If rural, give LOCATION)

2. (a) Th veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 9- 19 46 at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 9th 19 45 to Jan. 9th 19 46and that I last saw her alive on Jan. 9th 19 46

Immediate cause of death

Chronic Myocarditis

DURATION

1 yr.

Due to

Cerebral Sclerosis2 yrs.

Due to

Art. Sclerosis2 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James E. Nichols

M. D. or other

Address Baltimore, Md. Date signed 1/11/46

RECEIVED

JAN 14 1946

BUREAU V.R.

Mr. James Miller

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:  
County Balto.  
City or town Cwings Mills  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 Month 29 days  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Md. County Balto.  
City or town Cwings Mills  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Gwynbrook lane  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

3. (a) FULL NAME  
Carlton Eugene Peacher

3. (b) Social Security Number  
None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
8. AGE: Years Months Days It less than one day <u>1</u> <u>29</u> .....hrs. ....min.		

6. (c) If alive, give age ..... years  
8. (b) Name of husband or wife  
9. Birth date of deceased (mo., day, yr.) Nov. 4, 1945

10. Birthplace Balto. Co.  
(Town, county, and state)

11. Usual occupation None

12. Industry or business

12. Name Carlton P. Peacher

13. Birthplace Va.

14. Maiden name Ella F. Hall

15. Birthplace Va.

16. Informant Carlton P. Peacher

Address Cwings Mills, Md.

17. Burial Date thereof Jan 4, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory All Saints

Location Reisterstown, Md.

18. Funeral director J. F. Eline & Sons

Address Reisterstown, Md.

19. Jan 4 19 46 Mary Eline  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 19 46 at 9:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 19 46 to Jan 2 19 46 and that I last saw him dead Jan 2 19 46 alive on

Immediate cause of death Bronchitis & Laryngitis DURATION 4 da

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

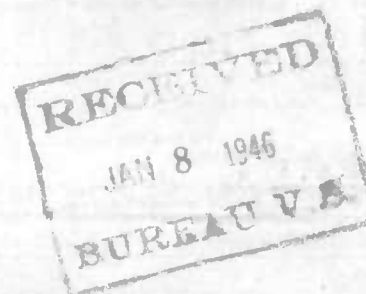
23. SIGNATURE J. D. Caples, M. D. Medical Examiner

Address Reisterstown, Md. Date signed 1-3-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

00286

### 1. PLACE OF DEATH: Baltimore

County.....

City or town..... Rosedale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Rosedale  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 3 Manor Place  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

### 3. (a) FULL NAME

Magdalena M Pearman

### 3. (b) Social Security Number

4. Sex.....

Female

5. Color or race.....

White

6.(a) Single, married, widowed, or divorced.....

Married

6.(b) Name of husband or wife..... George E Pearman

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... May 16 1882

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

63

8

7

9. Birthplace..... Pennsylvania  
(Town, county, and state)

10. Usual occupation..... At Home

11. Industry or business.....

12. Name..... Adam Sparr

13. Birthplace..... Sweden

14. Maiden name..... Magdaleha Wiemen

15. Birthplace..... Germany

18. Informant..... George E Pearmen

Address..... 3 Manor Place

17. Burial..... Date thereof..... 1/26/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Holy Redeemer

Location..... Belair Road

18. Funeral director..... Loasche Funeral Home

Address..... 7401 Belair Road

19. Date rec'd by registrar..... Jan. 25 45 John B. Smelly Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 23 1946 9.35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 45 to 19 46

and that I last saw him/her alive on 19 46

Immediate cause of death..... Haemiplegia Apoplectic

Due to..... Hypertension

Due to.....

Other conditions.....

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NAVY DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Dr. Rugicka

800 N Patterson Pl

Dudley

3323

E. Balto

RECEIVED

FEB 2 1946

BUREAU V. N.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 468

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

00287

1. PLACE OF DEATH:  
 County... Baltimore  
 City or town... Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year  
 Hospital, institution, or street address where death occurred:  
17 Alleghany Avenue  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... New Jersey County... Union  
 City or town... Elizabeth  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1201 Fairmount Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Ida Louise Pendleton

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife Arthur T. Pendleton  
 7. Birth date of deceased (mo., day, yr.) October 5, 1873 8.(c) If alive, give age — years  
 8. AGE: Years 72 Months 3 Days 12 If less than one day — hrs. — min.

9. Birthplace Mobile, Alabama  
 (Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home12. Name Felix Taylor Taliaferro13. Birthplace Orange, Va.14. Maiden name Annie Penny15. Birthplace Mobile, Alabama16. Informant Samuel T. PendletonAddress 17 Alleghany Ave., Towson, Md.17. Removal Date thereof Jan. 19, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory F.C. Oaden Funeral HomeLocation 458 Broad St., Elizabeth, N.J.18. Funeral director John Bussey, Inc.Address Towson, Md.19. Jan. 18 19 46 Wm. H. Johnson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1946 at 4:31 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1, 1945 to Jan 17, 1946  
 and that I last saw her alive on Jan 17, 1946Immediate cause of death Carcinoma - Pancreas

DURATION

Due to 17 monthsDue to 17 months

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

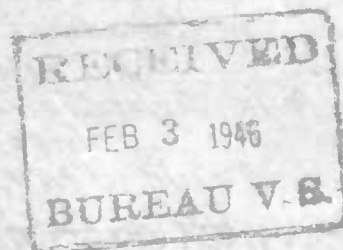
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. H. JohnsonAddress Towson, Md. Date signed 1/18/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00288

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County... CalvertCity or town... Calvert Green  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

HomeHow long in hospital or institution? 1 mon

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... CalvertCity or town... Calvert Green  
(If outside city or town limits, write RURAL and give nearest town)Street No. West  
(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

Annice Carol Aschett

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Charles F. Aschett

7. Birth date of

deceased (mo., day, yr.)

Sept. 8 1862

8. (c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

83329

hrs. min.

9. Birthplace

Home wife  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Permy F. Aschett

13. Birthplace

Calvert

14. Maiden name

Wally Aschett

15. Birthplace

Calvert

16. Informant

Ho Aschett

Address

West

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

St. Mary's

Location

Calvert Green

18. Funeral director

Address

Home19. Jan 19th 1946  
(Date rec'd by registrar)Harry H. Miller  
Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan 17 1946, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 17 1946 to Jan 17 1946

and that I last saw him alive on Jan 16 1946

Immediate cause of death

Intestinal Obstruction

DURATION

2 wks

Due to

Properable benign tumor of pancreas

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

same

Date of op. 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

James H. Aschett

M. D. or other

Address... Calvert Green Date signed 1-18

RECEIVED  
JAN 28 1946  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 0028936

## 1. PLACE OF DEATH:

County BaltimoreCity or town Calonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County BaltimoreCity or town Calonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 24 Prospect Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Calvin Hughes Poole

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Selma Schwenzler  
Poole7. Birth date of deceased (mo., day, yr.) May 1, 1888 6. (c) If alive, give age ..... years8. AGE: Years 57 Months 8 Days 28 It less than one day  
..... hrs. .... min.9. Birthplace Baltimore  
(Town, county, and state)10. Usual occupation Club (Retired)

## 11. Industry or business

12. Name Richard Poole13. Birthplace Ind14. Maiden name Laura15. Birthplace Ind16. Informant Mrs. Selma PooleAddress 24 Prospect Ave17. Burial Date thereof Feb. 1, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory WesternLocation Edmondson Ave + Logwood St18. Funeral director Sam H. WitkeAddress 4101 Edmondson Ave19. Jan 30 19 46 Barrett H. Miller  
(Date rec'd by registrar) (month) (year) Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 29 January 19 46 at 7:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
29 January 19 46 to 29 Jan 19 46and that I last saw him alive on 29 January 19 46Immediate cause of death Cerebral hemorrhage

DURATION

Due to Hypertension Unman

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stephen Lee Magness MD  
M. D. or otherAddress 7521 Frederick Ave Date signed 30 Jan 46

2 X4

Mr. Stephen Lee Magness,

752 Trek. Rd.

RECEIVED

JAN 31 1946

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age  
& birth date of deceased is  
shown on  
FILM No. I 00 FEB 8 1946

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

00290

38

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 mo. 15 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 4 mo. 15 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 136 Aisquith St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

ABRAHAM PORTNEY

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Anna Stelmach 6.(c) If alive, give age 78 years  
7. Birth date of deceased (mo., day, yr.) September 10, 1865-1872  
8. AGE: Years 73 Months -80- Days 4 16 hrs. min.  
9. Birthplace Poland  
(Town, county, and state)  
10. Usual occupation Presser  
11. Industry or business Cleaning and Pressing  
12. Name Louis Portney  
13. Birthplace Poland  
14. Maiden name Asney Cohen  
15. Birthplace Poland

16. Informant Hospital Records  
Address Catonsville 28, Maryland  
17. Burial Date thereof 5-28-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Herring Run  
Location Jack Lewis Inc  
18. Funeral director 1439 E Balto St  
Address  
19. 1-28 46 Harriet Miller  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 19 46, at 11:40 PM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
19 46, to 19 46  
and that I last saw him alive on 19 46

### Immediate cause of death

Murder

### Due to

Chronic Hepatitis  
Acute scleritis

### Due to

### Other conditions

Sudden death  
Injury  
(Include pregnancy within 3 months of death)

### Major findings of operations

### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

### 23. SIGNATURE

Dr. M. K. Miller 1-27-46  
M. D. or other  
Address 1010 Leeds an Date signed

RECEIVED

JAN 29 1946

BUREAU V C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 98-2

## CERTIFICATE OF DEATH

00291 30

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 months, 24 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 10 months, 24 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 22 South Athol Avenue Baltimore 29, Md  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ?

## 3.(a) FULL NAME

Max Pritzman

## 3.(b) Social Security Number

4. Sex..... male 5. Color or race..... white 8.(a) Single, married, widowed, or divorced..... single  
 6.(b) Name of husband or wife..... none 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) August 20, 1865  
 8. AGE: Years..... 80 Months..... 4 Days..... 13 If less than one day..... hrs. .... min.

9. Birthplace..... Germany  
 (Town, county, and state)  
 10. Usual occupation..... watchman  
 11. Industry or business..... ?  
 12. Name..... Wilhelm Pritzman  
 13. Birthplace..... Germany  
 14. Maiden name..... Louisa Dietzmann  
 15. Birthplace..... Germany

16. Informant..... Hospital Records  
 Address..... Catonsville, Balto-28, Md  
 17. Burial  
 (Burial, cremation, or removal. Which?) Date thereof..... Jan 9, 1946  
 (month) (day) (year)  
 Cemetery or crematory..... Western  
 Location..... Edmondson Ave  
 18. Funeral director..... Harry H. Witzke  
 Address..... 4101 Edmondson Ave  
 19. 43..... 50..... A. W. Neelgub  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 2..... 19 46 at 5:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....  
 and that I last saw him..... alive on..... 19.....

Immediate cause of death..... Acute Cardiac Failure  
 Due to..... Coronary vascular disease  
 Due to..... Sudden death  
 Other conditions..... Injury  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State).....  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....  
 23. SIGNATURE..... Dr. J. M. Kieffer.....  
 Address..... 1010 Leek Ave..... Date signed..... 1-2-46  
 M. D. or other.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

## CERTIFICATE OF DEATH

00292

Reg. Diat. No. 30

## 1. PLACE OF DEATH:

County BaltoCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 30 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Prince GeorgeCity or town Upper Marlboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Nora Randall

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Walter Albert Randall6. (c) If alive, give age 66 years7. Birth date of deceased (mo., day, yr.) Oct. 21, 18778. AGE: Years Months Days If less than one day  
68 2 15 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Upper Marlboro  
(Town, county, and state)10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Noah Fry13. Birthplace md.14. Maiden name Lucy Fowler15. Birthplace md.16. Informant Walter RandallAddress Upper Marlboro17. Initial Jan 6 46  
(Burial, cremation, or removal? Which?) Date thereof (month) (day) (year)Cemetery or crematory Prince Geo. Co., Md.Location " " " " " "18. Funeral director Richie B. B. B.Address Upper Marlboro, Md.19. 1-9 46 Harry W. Mullins

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 19 46 at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

DURATION

Acute cardiac failureDue to Coronary vascular diseaseDue to fractured left radiusOther conditions Colic fractureAccidental due to fall

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: gunAccident, suicide, or homicide Accident Date of Jan 6 46Where did injury occur? Catonsville, Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) hospitalMeans of injury Fall in bath room Injured at work? no23. SIGNATURE Dr. W. KiefferAddress 1010 Leeds Ave Date signed 1-15-46

RECEIVED  
JAN 10 1946  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for correction  
of birth date is shown on  
Film No. G100 - 2/23/46.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00293

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs 2 mo 24 da.

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital Catonsville Md.How long in hospital or institution? 3 yrs 2 mo 24 da.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ...City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3806 Co Hage Ave  
(If rural, give LOCATION)2(a) If veteran, name War ✓

## 3. (a) FULL NAME

William Reiner

## 3. (b) Social Security Number

4. Sex male5. Color or race white

6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife Annie Kustau7. Birth date of Jan. 28, 1883  
deceased (mo., day, yr.) Jan. 16, 19466. (c) If alive, give age 18/11/11 years8. AGE: Years 62 Months 6/8 Days 11 If less than one day 4 1/2 hrs. 15 min.9. Birthplace Russia  
(Town, county, and state)10. Usual occupation cigar packer

11. Industry or business

12. Name Jacob Reiner13. Birthplace Russia14. Maiden name Lease (surname unknown)15. Birthplace Russia16. Informant Records Spring Grove Hospital  
Address Catonsville 28, Md.17. Burial Date thereof 1-2-46  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory RosedaleLocation Phila Rd Hamilton Ave18. Funeral director Jack Lewis IncAddress 1439 E. Balto St.19. 1/2 19 45 A.W. Hedrick  
(Date rec'd by registrar) (year) (month) (day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 1, 1946 at 4:35 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 24, 1945 to Jan. 1, 1946and that I last saw him alive on Jan. 1, 1946Immediate cause of death Pneumonia DURATION 6 da.Due to Chronic myo carditis over 3 yrsDue to benign atherosclerosis over 3 yrs  
(Include pregnancy within 3 months of death)Major findings of operations none performedAutopsy results none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?23. SIGNATURE ... M. D. or otherAddress Spring Grove State Hospital Date signed 1-1-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

## CERTIFICATE OF DEATH

00294

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Catonsville  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 211 Westbourne Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Emma J. Rensch

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Widow6.(b) Name of husband or wife late Philip Rensch

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 18878. AGE: Years 58 Months 11 Days 29 If less than one day hrs. min.9. Birthplace Balto. Ind.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Frederick Kachule13. Birthplace Germany14. Maiden name Carolina Dietrich15. Birthplace Germany16. Informant Philip J. RenschAddress 211 Westbourne Rd.17. Burial Date thereof Jan. 31, '46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WesternLocation Edmondson Ave. + Longwood St18. Funeral director Harry H. LittleAddress 4101 Edmondson Ave.19. Jan. 30 19 46 Harry H. Miller  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 19 46 at 8:30 AM

I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 19 45 to Jan 28 19 46  
 and that I last saw her alive on Jan 27 19 46

Immediate cause of death Renal Cardiac Hypertension  
 Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Katherine Cox M. D. or otherAddress 537 W. Edmondson Pkwy Date signed Jan. 30, '46

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
JAN 31 1946  
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 38

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

(b) Registrar

## 2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(e) Citizen of foreign country?

(If rural give location)

(Yes or No)

If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 16 1946, at 10<sup>00</sup> A

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1945, to Jan. 16 1946, and that I last saw him alive on Jan. 16 1946.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

M. D.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 00295 320

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 Months 25 Days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 6 Months 25 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1825 Warwick Ave.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Bessie Harding Ford (Bessie Richardson)

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced  
 6. (b) Name of husband or wife 1 Benjamin Lee Ford  
2 Elmore Richardson B. (c) If alive, give age (2) 61 years  
 7. Birth date of deceased (mo., day, yr.) March 17, 1892  
 8. AGE: Years 53 Months 10 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation File Clerk  
 11. Industry or business \_\_\_\_\_

12. Name Victor S. Harding  
 13. Birthplace Maryland  
 14. Maiden name Mary Bishop  
 15. Birthplace Baltimore, Maryland

16. Informant Hospital records  
 Address Catonsville 28 Maryland  
 17. Burial Date thereof 1/22/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
Mt. Olive Cem.  
 Cemetery or crematory \_\_\_\_\_  
 Location Randallstown, Md.

18. Funeral director WM. J. TICKNER & SONS  
 Address Balto., Md.

19. 1/24 46  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 1946 at 10:00P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24, 1945 to January 18, 1946  
 and that I last saw h. er alive on January 18, 1946  
 Immediate cause of death Left Lower Lobe  
Pneumonia

DURATION  
10 hours

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Myrick W. Pullen, Jr. M. D. or otherAddress Spring Grove State Hospital Date signed 1/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45-2

## CERTIFICATE OF DEATH

00297

P

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltoCity or town Stonleigh  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Amacost Nursing Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Stonleigh  
(If outside city or town limits, write RURAL and give nearest town)Street No. 812 Register Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Minnie G. Riddick

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Clarence B. Riddick

7. Birth date of

deceased (mo., day, yr.)

June 21st 1885

8. AGE:

Years

Months

Days

If less than one day

60618

hrs.

min.

9. Birthplace

Halifax Co. N.C.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

FATHER

12. Name

Collin C. Gray

13. Birthplace

N.C.

MOTHER

14. Maiden name

Eliza White

15. Birthplace

N.C.

16. Informant

Albert P. Riddick

Address

324 E. Maple Rd. Linthicum Hgts17. Removal

Date thereof

1/11/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

SCOTLAND NECK

Location

SCOTLAND NECK, N.C.

18. Funeral director

William Cook Inc

Address

127 St. Paul St. Balto. 2 Md.19. 1-1019. 46Acute

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2nd 46, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1943, to Jan 9, 1946and that I last saw him alive on Jan 5, 1946

Immediate cause of death

Carcinoma - spine

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Chas. L. Baez

M. D. or other

Address

LinthicumDate signed 1-9-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00298

P

Reg. Dist. No. 44

<b>1. PLACE OF DEATH:</b> County <u>Baltimore</u> City or town <u>Fort Howard</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>4 days</u> Hospital, institution, or street address where death occurred: <u>Veterans Administration</u> How long in hospital or institution? <u>4 days</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County _____ City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>136 East Gitting Street</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>World War II</u>			
<b>3. (a) FULL NAME</b> <u>GEORGE M. RIGGIN</u>				<b>3. (b) Social Security Number</b> <u>216-01-4000</u>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>6. (b) Name of husband or wife</b> <u>Barbara Riffin</u>				<b>6. (c) If alive, give age</b> _____ years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>November 1, 1906</u>							
<b>8. AGE:</b> Years <u>39</u> Months <u>2</u> Days <u>8</u> If less than one day _____ hrs. _____ min.							
<b>9. Birthplace</b> <u>Baltimore, Maryland</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>Grocery checker</u>							
<b>11. Industry or business</b> _____							
<b>MOTHER</b>		<b>FATHER</b>					
<b>12. Name</b> <u>George Riffin</u>		<b>12. Name</b> <u>George Riffin</u>					
<b>13. Birthplace</b> <u>Maryland</u>		<b>13. Birthplace</b> <u>Maryland</u>					
<b>14. Maiden name</b> <u>Louise Robb</u>		<b>14. Maiden name</b> <u>Louise Robb</u>					
<b>15. Birthplace</b> <u>Baltimore, Maryland</u>		<b>15. Birthplace</b> <u>Baltimore, Maryland</u>					
<b>16. Informant</b> <u>Clinical Records, Veterans Adminis-</u> Address <u>tration, Fort Howard, Maryland</u>							
<b>17. <u>Burial</u></b> (Burial, cremation, or removal. Which?) Date thereof <u>1/12/46</u> (month) (day) (year) Cemetery or crematory <u>Baltimore National Cemetery</u> Location <u>5501 Frederick Ave. Balto.Md.</u>							
<b>18. Funeral director</b> <u>Martin W.E. Dippel</u> Address <u>Lombard &amp; Ann St. Balto.Md.</u>							
<b>19. <u>18/12</u></b> (Date filed by registrar) <u>46 a. H. Hedrick</u>							
<b>MEDICAL CERTIFICATION</b>							
<b>20. DATE OF DEATH</b> <u>January 9</u> 19 <u>46</u> , at <u>7:45P</u> M							
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>January 5,</u> 19 <u>46</u> , to <u>Jan. 9</u> 19 <u>46</u> and that I last saw him alive on <u>January 9,</u> 19 <u>46</u> Immediate cause of death <u>Uremia, acute, secondary to sulfonamide intoxication</u> DURATION <u>12 hrs</u> <u>xxx Pneumonia, Lobar, bilateral, severe, type undetermined</u> <u>2 wks.</u> <u>xxx Pleural Effusion, lt. secondary</u> Other conditions _____ (Include pregnancy within 8 months of death) Major findings of operations <u>None</u> Date of op. _____ Autopsy results <u>None</u> PHYSICIAN: Please underline the cause to which death should be charged statistically.							
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____ <u>45 Ann Balter</u> <b>23. SIGNATURE</b> <u>A.M. BALTER, LT. COL. M.C. CLIN. DIR.</u> M. D. or other _____ Address <u>Fort Howard, Md.</u> Date signed <u>1-10-46</u>							



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Ellicott City Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Ellicott City  
(If outside city or town limits, write RURAL and give nearest town)Street No. Westchester Ave  
(If rural, give LOCATION)

2.(a) If veteran, name War

## 3. (a) FULL NAME

Earl Lee Rockenbaugh

## 3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

married8. (b) Name of husband or wife Nette Rockenbaugh

8. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Nov. 11, 1975

8. AGE:

Years

Months

Days

If less than one day

70128

hrs.

min.

9. Birthplace

Black Co. Virginia  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER  
MOTHER

12. Name

Edward Rockenbaugh

13. Birthplace

Va

14. Maiden name

Emilia Boyd

15. Birthplace

Va.

16. Informant

Mrs. Nette Rockenbaugh

Address

Ellicott City Md.

17.

Burial

Date thereof

1-12-46  
(month) (day) (year)

Cemetery or crematory

Good Shepherd

Location

Ellicott City Md.

18. Funeral director

F.C. Nigubatham

Address

Ellicott City Md

19.

1-11

19

46Harry D. Miller  
Deputy Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 19 46, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/919 46, to1/919 46

and that I last saw him alive on

1/919 46

Immediate cause of death

Arteriosclerotic Cardiovascular  
disease

DURATION

3 years

Due to

Coronary Thrombosis5 hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George E. Buntch  
M. D. or other

Address

Ellicott City, Md.Date signed 1/10/46

SAC CONTENT

RECEIVED

JAN 14 1946

BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00300

Reg. Dist. No.

### 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Maryland

How long in hospital or institution?..... 6 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore Co.  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 811 Essex Avenue - Essex  
(If rural, give LOCATION)

2.(a) If veteran, name war..... W-I

### 3. (a) FULL NAME

CASPER G. ROMEAN

### 3. (b) Social Security Number

4. Sex.....

Male

5. Color or race.....

White

6.(a) Single, married, widowed, or divorced

Married--Sep.

6.(b) Name of husband or wife..... Mrs. Catherine Romean

6.(c) If alive, give age..... 53 years

7. Birth date of deceased (mo., day, yr.)..... Feb. 22, 1888

8. AGE: Years..... 57 Months..... 11 Days..... 6 If less than one day..... hrs. .... min.

9. Birthplace..... Pittsburgh, Pa.  
(Town, county, and state)

10. Usual occupation..... Unemployed

11. Industry or business

12. Name..... Joseph Romean

13. Birthplace..... Germany

14. Maiden name..... Agnes Butler

15. Birthplace..... Germany

10. Informant..... Clinical Records, Vets. Adm. Hosp.

Address..... Fort Howard, Maryland

11. Burial Date thereof..... Jan 31, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Baltimore National Cemetery

Location..... Baltimore, Maryland

10. Funeral director..... Lilly & Zeiler, Inc.

Address..... 403 South Wolfe St., Balto., Md.

19. 1/29 46 Registrar.....  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 28, 1946 at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 22, 1946 to January 28, 1946

and that I last saw him alive on January 28, 1946

Immediate cause of death

Tuberculosis, chr. pul. far adv.

DURATION

6 Mos.

plus

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE..... Ann Balter

A. M. BALTER, Lt. Col., M.C. Clin. Dir.

Address..... Ft. Howard, Md. Date signed..... 1-28-46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Residence by phone to Vets. Hosp. 2/1/46 as

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH  
age is shown on 2411 N. Charles St., Baltimore 932  
FILM No. 100 FEB 1 1946 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:  
County..... Balto.  
City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Paradise & Altamont Aves.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Md. County..... Balto.  
City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... Paradise & Altamont Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME  
EMMA L. ROSS

3. (b) Social Security Number  
None

4. Sex..... F  
5. Color or race..... W  
6. (a) Single, married, widowed, or divorced..... Widowed

6. (b) Name of husband or wife..... Oscar E. Ross, Sr.

7. Birth date of deceased (mo., day, yr.)..... Oct. 4, 1869  
6. (c) If alive, give age..... years

8. AGE: Years..... 76 Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace..... Balto., Md.  
(Town, county, and state)

10. Usual occupation..... At Home

11. Industry or business

12. Name..... Rubin Lewis

13. Birthplace..... Dorchester Co., Md.

14. Maiden name..... Laura Beazley

15. Birthplace..... Va.

16. Informant..... Mr. Oscar E. Ross, Jr.

Address..... Paradise & Altamont Rd, Catonsville

Burial..... 1/5/46

17. (Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)

Cemetery or crematory..... Loudon Park Cem.

Location..... Balto., Md.

18. Funeral director..... WM. J. TICKNER & SONS

Address..... Balto., Md.

19. 1/4 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 2, 1946 at 1:30 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 1934 to Jan 2 1946 and that I last saw her alive on Jan 1 1946

Immediate cause of death..... Myocarditis

Due to..... Hyper-tension

Due to..... Paroxysmal Atrial Fibrillation

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Dr. J. H. Felt

Address..... 208 E. Boston St. Date signed..... 1/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

00302

## 1. PLACE OF DEATH:

County.....Baltimore  
 City or town.....Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....62 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Ft. Howard, Maryland  
 How long in hospital or institution?.....62 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....  
 City or town.....Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1808 Bank Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....W-I

## 3. (a) FULL NAME

ROZGA, John W.

## 3. (b) Social Security Number

4. Sex.....Male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Married  
 6.(b) Name of husband or wife.....Rose Rozga  
 6.(c) If alive, give age.....47 years  
 7. Birth date of deceased (mo., day, yr.).....4-1-91  
 8. AGE: Years.....54 Months.....9 Days.....25 If less than one day..... hrs. min.  
 9. Birthplace.....Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation.....Laborer  
 11. Industry or business.....  
 FATHER 12. Name.....William Rozga  
 13. Birthplace.....Germany  
 MOTHER 14. Maiden name.....Marion ? (Mary Nowak)  
 15. Birthplace.....? Poland

18. Informant.....Clinical Records, Vets. Adm. Hosp.  
 Address.....Ft. Howard, Maryland  
 19. Burial Date thereof.....Jan. 30, 1946  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory.....St. Stanislaus Cemetery  
 Location.....Baltimore, Maryland  
M.F. Sadowski & Sons  
 18. Funeral director.....Sadoski Bros.  
 Address.....1808 Eastern Ave., Balto., Md.  
 19. 1/29 19 46 Superintendent  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....January 26, 1946..... 19..... at 4:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
November 25, 1946 to January 26, 1946  
 and that I last saw him alive on..... 19.....

Immediate cause of death.....Cerebral Thrombosis  
 DURATION

Due to.....Hemiplegia, Right

Due to.....

Other conditions.....Arteriosclerosis, general

(Include pregnancy within 8 months of death)

Major findings of operations.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....A. M. Balter  
A. M. BALTER, Lt. Col., M.C. Clin. Dir.  
 Address.....Ft. Howard, Md. Date signed.....1-26-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

### 1. PLACE OF DEATH:

County Calverton  
City or town Butler Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Down Road

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Butler  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Down Road  
(If rural, give LOCATION)

2.(a) If veteran, name war W

### 3. (a) FULL NAME

Katherine E. Rukert

### 3. (b) Social Security Number

none

4. Sex F. 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife George Rukert

6.(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1864

8. AGE: Years 81 Months 3 Days 27 If less than one day  
hrs. min.

9. Birthplace Baltimore  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Fredrick Menke

13. Birthplace Baltimore

14. Maiden name Unknown

15. Birthplace Germany

16. Informant H. G. Norman Rukert

Address Butler Md.

17. Burial Date thereof Jan 22, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory London Park

Location Balto Md

18. Funeral director William Coz Inc

Address 1207 14th St.

19. 1-21-46 Registrar Confidential

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1946 at 6:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30, 1946 to Jan 19, 1946

and that I last saw him alive on Jan 16, 1946

Immediate cause of death Cerebral Thrombosis

DURATION 2 mos

Due to arteriosclerosis, gen

+ coronary disease

Due to arteriosclerosis, cerebral

4 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Benneth A. Hosen

Address Lutherville M. D. or other 11/19/46

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
year of birth of deceased is  
shown on

FILM No. I 00 FEB 14 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7d

CERTIFICATE OF DEATH

00304

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Twenty days

Hospital, institution, or street address where death occurred:  
Spaulden Lodge

How long in hospital or institution? Twenty days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 909 Chauncey Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HARRY BARNEY SACKS

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife Annie Nee Cramer

7. Birth date of deceased (mo., day, yr.) November 8, 1877 1876

8. AGE: Years 68 Months Days It less than one day

hrs. min.

9. Birthplace LITHUANIA  
(Town, county, and state)

10. Usual occupation MERCHANT

11. Industry or business HARDWARE BUSINESS

12. Name Solomon Sacks

13. Birthplace LITHUANIA

14. Maiden name HANNAH BALSKE

15. Birthplace LITHUANIA

16. Informant Mr Louis Sacks

Address 909 Chauncey Ave

17. Burial January 25, 1946  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Mickro Lodess Cemetery

Location Norfolk Va

18. Funeral director Sol Levinson & Bros

Address 1124-1126 W North Ave

19. 1-24 46 a W Hefrich  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 23 19 46 at 8:57 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4 19 46 to January 23 19 46  
and that I last saw him alive on January 23 19 46

Immediate cause of death Cerebral Hemorrhage DURATION 15 min

Due to Hypertensive Cardio-vascular disease years

Due to Generalized arteriosclerosis years

Other conditions Acute depression 6 weeks.  
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur J. McCalland MD M. D. or other  
Spaulden Lodge  
Catonsville, Md Date signed Jan. 23, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

00305

★ Reg. Dist. No. 49

1. PLACE OF DEATH:  
 County Baltimore  
 City or town Raspeburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Raspeburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 12 E Ridge Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

M Frieda Sauerbrey

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Paul Sauerbrey  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Nov 26 1887  
 8. AGE: Years 58 Months 1 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Germany  
 (Town, county, and state)  
 10. Usual occupation At Home  
 11. Industry or business

12. Name ----- Brauer  
 13. Birthplace Germany

14. Maiden name Unknown  
 15. Birthplace

16. Informant Paul Sauerbrey  
 Address 12 E Ridge Road

17. Burial Date thereof 1/14/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Moreland Memorial Park  
 Location Taylor Ave

18. Funeral director Lassak's Funeral Home  
 Address 7401 Belair Road

19. Jan 11 - 19 46 Mrs. P. L. Rejzender  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 46 10:45 PM

21. I Certify that death occurred on the date above stated; that I attended deceased from June 7 19 44 to Dec 15 19 45  
 and that I last saw her alive on Dec 15 19 45

Immediate cause of death Pulmonary edema DURATION 10 min  
 Due to Rheumatic heart disease 15 years  
 Due to  
 Other conditions Diabetes mellitus 5 yrs  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of Injury Injured at work?

23. SIGNATURE R. H. Guller MD M. D. or other  
 Address Ridge Road, Dist-6 Date signed 1/14/46

RECEIVED TO THE NATIONAL STATE CHARTER

RECEIVED TO THE NATIONAL STATE CHARTER

RECEIVED  
JAN 16 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

00306

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville 28  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs. 9 mo. 0 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 6 yrs. 9 mo. 0 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1751 No. Castle St.  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

MARY A. SCHMITT

4. Sex 5. Color or race 8.(a) Single, married, widowed, or divorced

Female White Widowed6.(b) Name of husband or wife William A. Schmitt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 8, 18878. AGE: Years Months Days It less than one day  
59 0 19 ..... hrs. .... min.9. Birthplace Austria  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Jacob Koubek13. Birthplace Austria14. Maiden name Frances (unknown)15. Birthplace Austria18. Informant Hospital RecordsAddress Catonsville 28, Maryland17. Burial Date thereof Jan 30, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Mary's Redemptorist CemeteryLocation Belair Road, Baltimore, Md.18. Funeral director Albert J. SmithAddress 146 N. Chester Street19. 1/28 46 Coughlin  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 1946 at 7:05A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27, 1939 to January 27, 1946and that I last saw her alive on January 27, 1946Immediate cause of death Myocardial insufficiency

DURATION

IndefDue to Terminal Pneumonia 14 Hrs.Due to Carcinoma arising in the stomach with metastasis to liver 7 yrs.Other conditions Partial Gastrectomy done in 1939 7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations Operation in 1939 showed gastric carcinoma Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Myrick V. Pullen, Jr. M/D or otherAddress Catonsville 28, Md. Date signed 1/27/46

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore *Bd*

Reg. Dist. No. *0483*

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: **Baltimore**  
 (a) County \_\_\_\_\_  
 (b) City or town **6489 Kenwood Ave**  
 (If outside city or town limits, write RURAL and give town)  
 (c) Street address, hospital, or institution: \_\_\_\_\_  
 (d) Length of stay in hospital or inst. (yrs., mos., or days) \_\_\_\_\_  
 (e) Length of stay in this community (yrs., mos., or days) \_\_\_\_\_

2. HOME (USUAL RESIDENCE) OF DECEASED:  
 (a) State **Maryland** (b) County **Baltimore**  
 (c) City or town **Raspeburg**  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. \_\_\_\_\_ (If rural give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

3 (a) FULL NAME *Max Frederick Schott*

3 (b) If veteran, name war **No** 3 (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **White** 6 (a) Single, married, widowed, or divorced. **Widower**

6 (b) Name of husband or wife **Bertha E Schott**  
 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) **Apr 27 1874**

8. AGE: Years **71** Months **8** Days **21** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **State Wisconsin**  
 (Town, county, and state)

10. Usual occupation **Rural letter carrier**

11. Industry or business **U S Mail**

12. Name **Frederick Schott**

13. Birthplace **Germany**

14. Maiden Name **Wilhelmina Roeming**

15. Birthplace **Germany**

16 (a) Informant **Mrs Fredk Vogtman**

(b) Address **6006 Shady Spring Rd**

17 (a) **Burial** (b) Date thereof **1/20/46**  
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory **Moreland Memorial**  
 Location **Taylor Ave**

18 (a) Funeral director **Lassahn Funeral Home**

(b) Address **7401 Belair Road**

19 (a) **Jan. 18, 1946** (Date rec'd by registrar) **Mrs. G. P. Reiser** Registrar

### MEDICAL CERTIFICATION

20. Date of death **Jan 17** 19**46** at **11 A** M

21. I certify that death occurred on the date above stated; that I attended deceased from **Jan 16** 19**46**, to **Jan 17** 19**46** and that I last saw him alive on **Jan 17** 19**46**.

Immediate cause of death **Potomany Thrombosis** Duration **Sudden**

Due to **Arterio-Sclerotic - Cardiac - Vascular Disease**

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

### PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? \_\_\_\_\_ While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature **Geo. M. Baumgardner** M. D. or other

Address **Balto 6 md** Date signed **1-17-46**

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 23 1946  
BUREAU V.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

## CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: Baltimore  
County Catonsville  
City or town (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Wood's Nursing Home, 5501 Edmondson Ave.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State MD. County Baltimore  
City or town (If outside city or town limits, write RURAL and give nearest town)  
Street No. 2125 Penrose Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary A. Schwallenberg

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Late George E. Schwallenberg

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1875.

8. AGE: Years 71 Months 12 Days 12 If less than one day  
hrs. min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)

10. Usual occupation N.W.

11. Industry or business

12. Name Thomas J. Curran

13. Birthplace Ireland

14. Maiden name Mary A. Henley

15. Birthplace Ireland

16. Informant Mrs. Lawrence Collins (daughter)

Address 2125 Penrose Ave.

17. Burial (Burial, cremation, or removal. Which?) Jan. 29/46.  
(month) (day) (year)

Cemetery or crematory New Cathedral

Location Old Frederick Rd. Baltimore

18. Funeral director Harry H. Kutzler

Address 4701 Edmondson Ave.

19. Jan 29 1946  
(Date rec'd by registrar)

Registrar Harriett Miller

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25/46. 19... al...

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1942 to Jan 25 1946  
and that I last saw him alive on 19...

Immediate cause of death

Myocardial Failure

Due to

Due to Streptococcal arthritis

Other conditions C.V. Disease

Hypertension

Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Coolahan M.D.

Address 24 W. Fulton St. Date signed 1/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. John F. Coolahan  
24 N. Fulton Ave

Edon 1679.

RECEIVED

JAN 30 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CHANGE OF SECOND INITIAL:  
letter filmed 3-7-46 G100-L  
(also item 6b)

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County..... Baltimore  
City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 4 months, 17 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution?..... 4 months, 17 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Virginia County.....  
City or town..... Portsmouth  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 616 - 6th Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... ✓

### 3. (a) FULL NAME

George W. Scott

### 3. (b) Social Security Number

4. Sex..... male  
5. Color or race..... white  
6. (a) Single, married, widowed, or divorced..... married  
6. (b) Name of husband or wife..... Margaret Marjory Scott  
B. (c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.)..... July 13, 1870  
8. AGE: Years..... 75 Months..... 6 Days..... 2  
If less than one day..... hrs. .... min.

9. Birthplace..... Indiana  
(Town, county, and state)  
10. Usual occupation..... Laborer  
11. Industry or business..... ?  
12. Name..... Jim Scott  
13. Birthplace..... ?  
14. Maiden name..... Juliana Smith  
15. Birthplace..... ?

16. Informant..... Hospital records  
Address..... Catonsville-28, Md.  
17. Burial Date thereat..... 1-19-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... Evergreen Memorial Cemetery  
Location..... Portsmouth, Va.  
18. Funeral director..... Stewart and Mowan Company  
Address..... 108 West North Ave. Baltimore, Md.  
19. 1-16 19 46 A W Hoffmann  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 15 19 46 at 8:10 a.m.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 29 19 45 to January 15 19 46  
and that I last saw him alive on January 15 19 46  
Immediate cause of death.....  
Acute myocardial insufficiency 20 hrs.

DURATION  
Generalized arteriosclerosis Indef.  
Due to.....  
Due to.....  
Other conditions.....

(Include pregnancy within 3 months of death)  
Major findings of operations..... Date of op. ....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of .....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) .....  
Means of injury..... Injured at work?

23. SIGNATURE..... Isidore Turk M.D. or other  
Catonsville-28, Md. Date signed 1-15-46  
Address.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8200

00310

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month, 14 daysHospital, institution, or street address where death occurred:  
Spring Grove State HospitalHow long in hospital or institution? 1 month, 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore-30  
(If outside city or town limits, write RURAL and give nearest town)Street No. 109 East Randall Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary A. Sebra

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Lloyd Sabra8. (c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) May 27, 18938. AGE: Years 52 Months 7 Days 8 If less than one day  
..... hrs. .... min.9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business HomeFATHER 12. Name Jolen H. Humphries13. Birthplace VirginiaMOTHER 14. Maiden name Lillie Dawson15. Birthplace Virginia16. Informant Hospital recordsAddress Catonsville-28, Maryland17. Burial Date thereof July 7, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Northumberland Co VaLocation Northumberland Co Va18. Funeral director G. Howard Evans, SonAddress 1400 S. Charles St. Bldg 1619. 1-6 19 46 Harold Miller  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 19 46 at 3:50 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
November 21 19 45 to January 4 19 46and that I last saw her alive on January 4 19 46

Immediate cause of death

Broncho pneumonia, bilateral 3 das.Due to Cerebral-vascular accident 7 das.Due to Cerebral arteriosclerosis Indef.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or otherAddress Catonsville-28, Md. Date signed 1/4/46

RECEIVED

JAN 8 1945

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 00311

## 1. PLACE OF DEATH:

County Balto. Co.  
 City or town 621 Aldershot Road  
Catoonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Margaret A. Seiler

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

late Jacob F. Seiler

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Oct. 8, 1870

8. AGE:

Years 75Months 3Days 1

If less than one day

hrs.

min.

9. Birthplace

Ind.  
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER  
MOTHER

12. Name

Andrew Anderson

13. Birthplace

Denmark

14. Maiden name

Harriett Hutchins

15. Birthplace

England

16. Informant

Mr. Roy Seiler

Address

621 Aldershot Road

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 12/46  
(month) (day) (year)

Cemetery or crematory

London Pl.

Location

3801 Frederick Rd.

18. Funeral director

Harry H. Wittle

Address

4101 E. Edmondson Ave.

19.

(Date rec'd by registrar)

11/7/46

19

11/7/46a. H. Hedrick

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Ind.

County

Catoonsville

City or town

621 Aldershot Road  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

621 Aldershot Road  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 9 1946 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 14 1945 to Jan 7 1946and that I last saw him/her alive on Jan 7 1946

Immediate cause of death

Arterio-sclerotic Cardiac -  
vascular Disease

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

23. SIGNATURE

C. P. Ros King

M. D. or other

Address 1314 N. Lombard St.Date signed 1/10/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

## CERTIFICATE OF DEATH

00312

Reg. Dist. No. 57

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville  
 (If outside city or town limits write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Cockeysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. York Rd.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

William Marion Seitz

## 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Florence A. Keller  
 6. (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1873

8. AGE: Years 72 Months 3 Days - If less than one day  
 hrs. min.

9. Birthplace Balto. Co. Md.  
 (Town, county and state)

10. Usual occupation Genl. Store Clerk

## 11. Industry or business

12. Name Noah Seitz

13. Birthplace York, Penna.

14. Maiden name Catherine Seitz

15. Birthplace Balto. Co. Md.

16. Informant Mrs. Win. F. Dunge

Address Cockeysville Md.

17. Burial Date thereof 1, 15, 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Weslops Methodist

Location Sparks, Md.

18. Funeral director Landou M. Brooks

Address Sparks, Md.

Jan. 13 1946 Wilmer C. Ensor  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 19 46 at 5:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 76 19 46 to Jan 13 19 46

and that I last saw him 4 hrs alive on Jan 13 19 46

Immediate cause of death Central

Pneumonia

Due to suppuration

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Elijah B. Shewill, M.D.

Address Cockeysville, Md. Date signed Jan 13, 46

RECEIVED  
JAN 15 1946  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 546

## CERTIFICATE OF DEATH

Reg. Dist. No. 00313

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Ft. Howard, Md.  
How long in hospital or institution? 2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1945 Harlem Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war WW-II

### 3. (a) FULL NAME

ROLAND LEON SENN

### 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mrs. Frances E. Senn

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) June 13, 1902

8. AGE: Years 43 Months 6 Days 30 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace North Carolina  
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business \_\_\_\_\_

FATHER 12. Name William Senn  
13. Birthplace South Carolina

MOTHER 14. Maiden name Elizabeth Livingston  
15. Birthplace South Carolina

16. Informant Clinical Records, Vets. Adm.  
Address Fort Howard, Md.

17. Burial Date thereof 1/5/46  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory Loumar  
Location Balto. Co. Md.

18. Funeral director William Cook Inc  
Address 1217 St. Paul st

19. 1-4- 46  
(Date rec'd by registrar) 19 \_\_\_\_\_  
AW 7/4/46  
ada Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH D January 3 19 46 at 1:20 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 19 46 to Jan. 3 19 46  
and that I last saw him alive on January 3, 1946 19 \_\_\_\_\_

Immediate cause of death Brain Tumor, malignant  
DURATION 1 mo.  
plus

Due to Duration at least 12 months

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE AM BALTER L.T. COL. M.C. CLIN. DIR.  
M. D. or other \_\_\_\_\_  
Address Fort Howard, Md. Date signed 1-3-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

00314

Reg. Dist. No. 38~

## 1. PLACE OF DEATH:

County BaltimoreCity or town Parkton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Parkton  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Henry Sheets

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

WidowedB. (b) Name of husband or wife Emma A Sheets

## 7. Birth date of

deceased (mo., day, yr.)

March 11, 1852

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

93101

hrs.

min.

## 9. Birthplace

York Co., Penna.  
(Town, county, and state)

## 10. Usual occupation

Night watchman

## 11. Industry or business

MOTHER FATHER

## 12. Name

Frederick Sheets

## 13. Birthplace

Middletown, Pa.

## 14. Maiden name

Unknown

## 15. Birthplace

## 16. Informant

Address

Mrs. Russell Hosball  
Parkton, Md.

## 17.

(Burial, cremation, or removal, Which?)

Date thereof

January 15, 1946  
(month) (day) (year)

Cemetery or crematory

Lutheran Cemetery

Location

Manchester, Pa.

## 18. Funeral director

Address

Jacat Hartenstein  
New Freedom, Pa.

## 19.

(Date rec'd by registrar)

Jan 13 1946  
Leahy G. G. G.  
Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1946 at 9:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 8, 1946 to Jan 12, 1946and that I last saw him alive on Jan 12, 1946Immediate cause of death Coronary Thrombosis

DURATION

4 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Emilur Bortner Jr. D.

M. D. or other

Address White Hall Date signed Jan 13, 1946

RECEIVED  
FEB 3 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

Reg. Dist. No. 00315 33

## 1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltoCity or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 18 Berryman's Lane  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret L. Shelton

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Thomas T. Shelton6. (c) If alive, give age 84 years

7. Birth date of

deceased (mo., day, yr.)

March 3, 1865

8. AGE:

Years

Months

Days

If less than one day

8080826

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Joseph Cooper

13. Birthplace

Maryland

MOTHER

14. Maiden name

Christina Baker

15. Birthplace

Maryland

16. Informant

Thomas T. Shelton

Address

18 Berryman's Lane17. Burial

(Burial, cremation, or removal. Which?)

Date thereon

Feb 1, 1946  
(month) (day) (year)

Cemetery or crematory

Middletown

Location

Balto Co. Md.

18. Funeral director

Chenoweth & Bonner

Address

3615-17 Chestnut Ave, Balto Md19. 1 - 31

(Date rec'd by registrar)

19 46Mary B. Eline

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 1946, at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1-36 to 1-30-46  
and that I last saw him alive on 1-29-46

Immediate cause of death

Myocarditis - chronic

DURATION

5 yrs

Due to

hypertension

✓

Due to

arteriosclerosis10 yrs

Other conditions

Diabetes15 yrs

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Mary L. Eline

M. D. or other

Address

Pikesville MdDate signed 1-31-46



RECEIVED  
FEB 2 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73

## CERTIFICATE OF DEATH

00316

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. 200 Wilder Drive  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Estella Lee Shields

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Walter Shields

7. Birth date of deceased (mo., day, yr.)

Dec 17 18888. AGE: Years 57 Months — Days 20 If less than one day9. Birthplace Balto Co. - Maryland  
(Town, county, and state)10. Usual occupation At home

11. Industry or business

12. Name R. E. Lee Bosley13. Birthplace Maryland14. Maiden name Mollie Musgrove15. Birthplace Maryland16. Informant Mrs. R. E. Lee BosleyAddress 200 Wilder Drive Towson17. Burial Date thereof Jan 10-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Prospect HillLocation Towson, Maryland18. Funeral director Burpee Funeral HomeAddress 3631 Falls Road Baltimore19. Jan. 9, 1946 Date rec'd by registrarRegistrar John J. [illegible]

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1946 at 7:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 1945 to Jan 7 1946 and that I last saw him alive on Jan 5 1946Immediate cause of death Myocardial Infarction

Due to

Due to

Other conditions Hypertension  
General Anasarca  
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. O. Sellman MDAddress 605 Baltimore Ave Towson M. D. or otherDate signed Jan 7 46

RECEIVED  
JAN 15 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

00317

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Beggs Forge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Baltimore  
 City or town Beggs Forge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 418 Dunkirk Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Merrill Shinnick Jr.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Sadie C. Shinnick  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Oct. 22, 1886  
 8. AGE: Years 59 Months 2 Days 205 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore Md.  
 (Town, county, and state)

10. Usual occupation State Pilot

11. Industry or business Maryland Pilot Association

12. Name Joseph M. Shinnick

13. Birthplace Baltimore Md.

14. Maiden name Clara Frey

15. Birthplace Baltimore Md.

16. Informant Merrill Shinnick Jr.

Address 208 Dunkirk Road

17. Burial Date thereof 1/19/46  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory London Park

Location Balto Md.

18. Funeral director William G. G. Inc.

Address 1217 St. Paul St.

19. 4-18 19 46 W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 19 46 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 19 46 to Jan 17 19 46

and that I last saw him alive on Jan 17 19 46

Immediate cause of death Acute Pulmonary Edema

Due to Coronary Thrombosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Geo. McLean

Jo Smedley M. D. or other \_\_\_\_\_

Address 1217 St. Paul St. Date signed 1-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

00318

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 32 days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Fort Howard, Md.  
 How long in hospital or institution? 32 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1708 N. Bethel St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war /SAW

## 3. (a) FULL NAME

ROBERT L. SHIPLEY

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife Anna Kuschling  
 7. Birth date of deceased (mo., day, yr.) May 7, 1880 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 65 Months 8 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Painter  
 11. Industry or business \_\_\_\_\_

12. Name Unknown  
 13. Birthplace Unknown  
 14. Maiden name Carrie Bobart  
 15. Birthplace Unknown

16. Informant Veterans Adm. Clinical Records  
 Address Fort Howard, Md.

17. Burial Date thereof Jan 11 - 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Western  
 Location Edmondson ave.

18. Funeral director Blanche F. Hoffmann  
 Address 1639 N Broadway

19. 1-10 18  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 19 46 at 7:04 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 7 19 45 to Jan. 8 19 46  
 and that I last saw him alive on January 8 19 46

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_  
Hypertensive & Arteriosclerotic  
Heart Disease with decompensation 24 hrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. M. BALTER L.T. COL. M.C. CLIN.Address Fort Howard, Md. Date signed 1-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Catonsville Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Seven months  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? Seven months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1016 Webb Court  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ida May Shoemaker

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Lannae Shoemaker 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) February 22, 1863  
 8. AGE: Years 82 Months 11 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Baltimore County, Maryland.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business None  
 12. Name Henry D. Muth  
 13. Birthplace Pennsylvania  
 14. Maiden name Mary Tase  
 15. Birthplace Pennsylvania

16. Informant Hospital Records  
 Address Catonsville, 28, Md.  
 17. Burial Date thereof 1/29/46  
 (Burial, cremation, or removal, which) (month) (day) (year)  
 Cemetery or crematory Mossland Park  
 Location Parkville, Md.  
 18. Funeral director William Cook Inc  
 Address 127 St. Paul St.  
 19. 1/28 46 Cook  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 26, 1946 19 \_\_\_\_\_ at 12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 26 19 45 to January 26 19 46

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

Chronic parenchymatous nephritisDURATION  
Indef

Due to Chronic hypertensive C-V-R  
Disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE \_\_\_\_\_ M. D. or other

Henry C. A. Mead, M.D.  
 Address Catonsville, 28, Md. Date signed 1/26/46



100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

00320

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 yrs 1 mo., 14 days  
 Hospital, institution, or street address where death occurred:  
 Spring Grove State Hospital  
 How long in hospital or institution? 10 years, 1 mo., 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 725 West North Avenue  
 (If rural, give LOCATION)  
 2(a) If veteran, name war.....

## 3. (a) FULL NAME

Cecilia Siegael

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Samuel Siegael  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) Unknown  
 8. AGE: Years 75? Months Days If less than one day hrs. min.  
 9. Birthplace Russian (Town, county, and state)  
 10. Usual occupation Housekeeper  
 11. Industry or business Home  
 12. Name Israel Sacks  
 13. Birthplace Russia  
 14. Maiden name Fannie - (Last name?)  
 15. Birthplace Russian

16. Informant Hospital Records  
 Address Catonsville, 28, Md.  
 17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 14-46 (month) (day) (year)  
 Cemetery or crematory Resurrection  
 Location Bowleys Lane + Childs Rd  
 18. Funeral director Jack Lewis  
 Address 1439 E. Balto  
 19. 1/14 1946 Harry W. Miller (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1946 19 at 9:20 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death  
 acute cardiac failure  
 Due to cerebral vascular disease  
 Due to fracture right femur  
 Other conditions accident surgical neck  
 (Include pregnancy within 3 months of death)

## DURATION

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of Dec 19, 45  
 Where did injury occur? Catonsville Balto and (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) Hospital  
 Means of injury fall on floor Injured at work? no  
 23. SIGNATURE Harry W. Miller M. D. or other  
 Address 1010 Leeds an Date signed 1-13-46

RECEIVED

JAN 15 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (56)

## CERTIFICATE OF DEATH

Reg. Diat. No. 01072  
40

## 1. PLACE OF DEATH:

County BaltimoreCity or town Notch Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Notch Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name War \_\_\_\_\_

## 3. (a) FULL NAME

Sister Mary Petronilla Stetter

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) March 31, 1877

8. AGE: Years Months Days It less than one day

68921

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Teacher

11. Industry or business

12. Name Charles Stetter13. Birthplace France14. Maiden name Margaret Roth15. Birthplace Bavaria16. Informant Sr. Mary C ParaAddress Notch Cliff, Md.17. Burial Date thereof Jan 22/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Notch CliffLocation Green18. Funeral director Geo M. FriskisonAddress 811 N. Wolfe St19. 1/21/46 19 11/21/46

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 19 46 at 7.30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 27 19 44 to Jan 20 19 46and that I last saw her alive on Jan 14/46 19 46Immediate cause of death Carcinoma

## DURATION

Primary in breast cancerDue to Duration: Three years

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature John GreenAddress \_\_\_\_\_ Date signed Jan 20/46

RECEIVED

MAR 13 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

## CERTIFICATE OF DEATH

Reg. Dist. No. 80

00325

## 1. PLACE OF DEATH

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Road of 6309 Frederick Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

George B. Stiebing

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) August 16, 1874

8. AGE:

Years

Months

Days

If less than one day

7152hrs.min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Odd jobs

MOTHER FATHER

12. Name

Henry A. Stiebing

13. Birthplace

Germany

14. Maiden name

Charlotte Eichner

15. Birthplace

Germany

18. Informant

John G. Stiebing

Address

4807 Beacon Ave. Arbutus

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Cemetery or crematory

London Park

Location

Baltimore, Maryland

18. Funeral director

George L. Schwal

Address

2101 Frederick Avenue

19. (Date rec'd by registrar)

Jan. 17, 1946Harry S. MillerDeputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1946, at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19and that I last saw h. alive on 19

Immediate cause of death

Myocardial infarction

DURATION

Due to

Coronary atherosclerosis

Due to

None

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm. H. Kieffer

M. D. or other

Address 1010 Lehigh Ave.Date signed 1-19-46



200-

RECEIVED

JAN 19 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 00336

## 1. PLACE OF DEATH:

County CatonvilleCity or town Balti. Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 1/2

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Catonville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 146 Winters Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Cecelia E. Smith

## 3. (b) Social Security Number

4. Sex F5. Color or race C6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth data of deceased (mo., day, yr.) 1-3-18638. AGE: Years 83 Months Days If less than one day hrs. min.9. Birthplace Alexander Va  
(Town, county, and state)10. Usual occupation Homemaker

11. Industry or business

12. Name Alexander Cole13. Birthplace Va.14. Maiden name Rachel Cole15. Birthplace Va.16. Informant Raymond SmithAddress 146 Winters Ave.17. Burial Date thereof 1-7-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Western Star CemeteryLocation Md.18. Funeral director Holmes HalsteadAddress 918 Elm Hill Ave.19. 1-7-46 U W Hedrick  
(Date rec'd by registrar) 19 46 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4<sup>th</sup> 19 46 at 6:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec-1st 19 45 to Jan 4<sup>th</sup> 19 46  
and that I last saw him alive on 19

Immediate cause of death

DURATION

Mitral Insufficiency &  
Due to Arteriosclerosis ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edith Maloney MD M. D. or otherAddress Catonville, Md. Date signed 1/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (922)

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

00322

## 1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 48 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, MarylandHow long in hospital or institution?..... 48 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 506 N. Fulton Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war..... SAW

## 3.(a) FULL NAME

SMITH, Frank E.

## 3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife..... Laura M. Smith6.(c) If alive, give age..... 67 years7. Birth date of deceased (mo., day, yr.)..... 6-16-758. AGE: Years Months Days If less than one day  
70 7 4 ..... hrs. .... min.9. Birthplace..... Hagerstown, Md.  
(Town, county, and state)10. Usual occupation..... Unemployed

11. Industry or business

12. Name..... Eugene Smith13. Birthplace..... Maryland14. Maiden name..... Jennie Ford15. Birthplace..... Maryland16. Informant..... Clinical Records, Vets. Adm. Hosp.Address..... Ft. Howard, Md.17. Cremial Date thereof..... 1-24-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Baltimore National CemeteryBaltimore, Maryland

Location

18. Funeral director..... George E. TaylorAddress..... Catonville Md.19. Jan. 22nd 46 Harry S. Miller  
(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 21, 1946 10:15A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 4, 1945, to January 21, 1946and that I last saw h..... Im alive on January 21, 1946Immediate cause of death..... Disease of the Heart

DURATION

Hypertension & Coronary Arterio-  
sclerosis-Aortic stenosis-Myocardial  
xxx insufficiency

Due to.....

Other conditions..... Arteriosclerosis, cerebral  
with psychosis  
(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... A.M. BALTER Lt. Col., M.C. or otherAddress..... Clinical Director Date signed..... 1-21-46

RECEIVED

JAN 23 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town 54 Yalmhurst Ave Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Haven CountyCity or town Connecticut  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)2.(a) If veteran, name war None ☒

## 3. (a) FULL NAME

Louise Adele Smith

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widow6.(b) Name of husband or wife Ellis Eugene Smith

6.(c) If alive, give age ..... years

## 7. Birth date of deceased (mo., day, yr.)

Dec. 31, 1885

## 8. AGE:

Years 60 Months — Days 28 It less than one day

hrs. min.

9. Birthplace New Brunswick, Canada

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Charles Carpenter13. Birthplace Nova Scotia14. Maiden name Arthura Wawer15. Birthplace Nova Scotia16. Informant Mrs. Hazel S. FassetAddress 54 Yalmhurst Ave Catonsville17. Burial Date thereof Feb. 1, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sturbridge CemeteryLocation Sturbridge, Mass.18. Funeral director Easton SonsAddress Catonsville, Md.19. Jan 29 19 46 Harry Miller

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 19 46 at 8:30 P.M.I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25 19 46 to January 25 19 46and that I last saw him alive on January 25 19 46Immediate cause of death Acute cardiac dilatationDURATION 1 da.Due to La Grippe 2 wks.

Due to

Other conditions Diabetes 10 yr.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William K. Gallagher M.D.Address Catonsville, Md.Date signed 1-28-46

RECEIVED  
JAN 30 1946  
BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

00324-

Reg. Diat. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Beltsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

315 Ingleside Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Beltsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name War \_\_\_\_\_

## 3. (a) FULL NAME

Margaret O'Neill Stearns

## 3. (b) Social Security Number

none4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow8. (b) Name of husband or wife Wm F Stearns7. Birth date of deceased (mo., day, yr.) 1861 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 85 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Ireland  
(Town, county, and state)10. Usual occupation at home

## 11. Industry or business

12. Name Thomas O'Neill13. Birthplace Ireland14. Maiden name unknown15. Birthplace "16. Informant Frank BarrettAddress Beltsville Md17. Burial Date thereof 1-30-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St LouisLocation Clarksburg, Md18. Funeral director F.C. HigginbothamAddress Ellicott City Md.19. Jan 29 19 46 Shirley Miller  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 19 46 at 9:30 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 46 to Jan 27 19 46and that I last saw h. er alive on Jan 27 19 46

Immediate cause of death \_\_\_\_\_

DURATION

Bruselated pneumonia6 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE Jim P. Kishman, M.D. M. D. or otherAddress Ellicott City Md Date signed 1-28-46

RECEIVED

JAN 30 1946

BUREAU V.S.

ARTICAN LEADER

FRONTIER

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:  
County Baltimore Co  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 months  
Hospital, institution, or street address where death occurred Hoods Nursing Home  
5501 Edmondson Ave  
How long in hospital or institution 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Baltimore Co  
City or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6732 Windsor Mill Road  
(If rural, give LOCATION)  
2. (a) If veteran, name war

3. (a) FULL NAME Elizabeth Katherine Stratmeyer

3. (b) Social Security Number

4. Sex female  
5. Color or race white  
6. (a) Single, married, widowed, or divorced widowed

8. (b) Name of husband or wife Henry C. Stratmeyer

7. Birth date of deceased (mo., day, yr.) July 15 1871  
8. AGE: Years 74 Months 5 Days 21 If less than one day  
8. (c) If alive, give age years

9. Birthplace Baltimore Maryland  
(Town, county, and state)

10. Usual occupation housekeeper

11. Industry or business own home

12. Name John Frederick Roeseke

13. Birthplace Germany Huefling

14. Maiden name Katherine Hoefling

15. Birthplace Germany

16. Informant Mrs. Emma Tiller

Address 4028 North Rogers Ave

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 9, 1946  
(month) (day) (year)

Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Md.

18. Funeral director Mellie Lamoreaux

Address 4510 Liberty Heights Ave.

19. 1-8 Dec 20 Neel  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1946 at 945 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 5 1946

and that I last saw her alive on Jan 5 1946

Immediate cause of death Chronic Myocardial Degeneration

Due to Chronic Nephritis

Other conditions Chronic Nephritis

(Include pregnancy within 8 months of death)

Major findings of operations no operation

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joshua H. Armistead MD

Address 6419 Windsor Mill Rd

Date signed Jan 7 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 003228

## 1. PLACE OF DEATH:

County BALTIMORECity or town TOWSON  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 years, 1 month, 25 days

Hospital, institution, or street address where death occurred:

THE SHEPPARD AND ENOCH PRATT HOSPITALHow long to hospital or institution? 14 years, 1 month, 25 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania CountyCity or town Philadelphia  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6524 N. Seventh St., Oak Lane  
(If rural, give LOCATION) ✓

2.(a) If veteran, name war

## 3. (a) FULL NAME

JOSEPH C. SULLIVAN

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

8. (c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.) August 26, 1866

## 8. AGE:

Years

Months

Days

If less than one day

79423

hrs.

min.

9. Birthplace Avondale, Penna.  
(Town, county, and state)10. Usual occupation Dry goods merchant

11. Industry or business

## FATHER

12. Name Cornelius Sullivan13. Birthplace Ireland

## MOTHER

14. Maiden name Julia Gleason15. Birthplace Ireland16. Informant HOSPITAL RECORDS

Address

17. Burial Date thereof Jan. 22/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy SepulchreLocation Philadelphia, Pa.18. Funeral director John O. Mitchell & Son Inc.Address 1900 Cutawh Place19. Jan. 20 19 46 W. W. Elgin Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 19 46 at 6:00 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
November 24 19 31 to January 19 19 46  
and that I last saw him alive on January 19 19 46

Immediate cause of death

Pulmonary embolism

DURATION

Terminal

Due to

Generalized  
ArteriosclerosisUnknown

Due to

Other conditions Manic depression psychosis20 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Conforms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. W. ELGIN, M. D. M. D. or otherAddress TOWSON, MD. Date signed Jan. 19, 1946

CERTIFICATE OF DEATH

RECEIVED  
FEB 3 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

## 1. PLACE OF DEATH:

County BaltimoreCity or town Raspeburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Raspeburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 16 Delight Ave  
(If rural, give LOCATION)2.(a) If veteran, name war No

## 3. (a) FULL NAME

Adele K Tagg

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife George C Tagg

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27 1891

8. AGE: Years Months Days It less than one day

54112

hrs.

min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name John A Keith13. Birthplace Maryland14. Maiden name Nellie McKewen15. Birthplace Maryland16. Informant Mrs Chas. HurleyAddress 110 W Elm Ave17. Burial Date thereof 1/12/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory ParkwoodLocation Taylor Ave18. Funeral director Laxah Funeral HomeAddress 7401 Belair Road19. Jan 9-1946 Mrs. G.L. Ruffin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 46 9.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 30 1945 to Jan 8 46and that I last saw him alive on Jan 8 46Immediate cause of death Cerebral hemorrhage DURATION 3 daysDue to Hypertensive Cardio-vascular disease 5 yrsDue to PneumoniaOther conditions (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James L. Teller MD M. D. or otherAddress Ridge Road, Bect-6 Date signed 1/9/46



UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

JAN 14 1946

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

## CERTIFICATE OF DEATH

00329

Reg. Dist. No. 9830

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 7 years, 2 months, 11 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution?..... 7 years, 2 months, 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil  
 City or town..... Perryville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Robert T. Taylor

## 3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Annie M. Taylor  
 6.(c) If alive, give age..... 2 years  
 7. Birth date of deceased (mo., day, yr.)..... January 23, 1886  
 8. AGE: Years..... 59 Months..... 11 Days..... 23 If less than one day..... hrs. .... min.  
 9. Birthplace..... Maryland  
 (Town, county, and state)  
 10. Usual occupation..... Telegrapher  
 11. Industry or business..... Telegraph  
 12. Name..... William Taylor  
 13. Birthplace..... Blythedale, Maryland  
 14. Maiden name..... Eleanora Jackson  
 15. Birthplace..... Blythedale, Maryland  
 16. Informant..... Hospital records  
 Address..... Catonsville-28, Md.

17. Burial..... Date thereof..... Jan. 18, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Hopewell Cemetery  
 Location..... Port Deposit, Rural, Md.  
 18. Funeral director..... W. A. Patterson & Son  
 Address..... Perryville, Md.  
 19. Date rec'd by registrar..... Jan. 16, 1946 Registrar..... James E. Doughty

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 15, 1946 at..... 7:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....  
 and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

DURATION

Acute Cardiac failureDue to..... Arterio vascular disease

Due to.....

Other conditions..... Sudden death

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

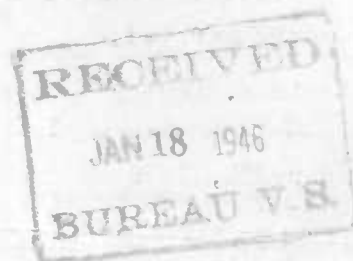
Means of injury..... Injured at work?

23. SIGNATURE..... Wm. L. Kieffer Deaf Oked

M. D. or other

Address..... 1010 Leachman Date signed..... 1-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The current age is especially important. Physicians: please write the causes of death clearly and fully.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

00330

## 1. PLACE OF DEATH

County Balto.Village or City EggenereRegistration Dist. No. 44No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U.S. if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## 2. FULL NAME

(a) Residence: No. \_\_\_\_\_

(Usual place of abode)

St. \_\_\_\_\_ Ward. \_\_\_\_\_

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W5. SINGLE, MARRIED, WIDOWED,  
OR DIVORCED (write the word)married5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofMargaret ?

6. DATE OF BIRTH (month, day, and year)

1888

7. AGE

58

Years

Months

Days

If LESS than  
1 day \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.Shipyards9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.10. Date deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation12. BIRTHPLACE (city or town)  
(State or country)Hungary

13. NAME

Joseph Teubl14. BIRTHPLACE (city or town)  
(State or country)Hungary

15. MAIDEN NAME

Josephine Janos16. BIRTHPLACE (city or town)  
(State or country)Hungary17. INFORMANT  
(Address)Yorkville Funeral Service  
1649 1st. ave. N. Y. City

18. BURIAL, CREMATION, OR REMOVAL

Place St. Michaels Date 1/5/ 194619. UNDERTAKER  
(Address)Steward & Mowen Co.  
108 W North Ave.

20. FILED

1/5/ 1946 John V. Connelly  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

Jan 4 1946  
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from

Jan 4, 1946, to \_\_\_\_\_, 19\_\_\_\_

I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; death is said

to have occurred on the date stated above, at 1:45 p.m.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:Coronary occlusion

Date of onset

Immediate

Other Contributory Causes of Importance:

Acute alcoholism15 yrs.

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of Injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

J. J. McLaughlin M.D.  
Sept. Medical Examiner

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

00331

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 year, 11 months.  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 2 year, 11 months.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1311 West 42nd Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Theresa Thomas

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) May 1867? 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 78? Months 8? Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)  
 10. Usual occupation Laborer (forelady)  
 11. Industry or business Factory  
 12. Name Patrick Thomas  
 13. Birthplace Ireland  
 14. Maiden name Catherine Cochran  
 15. Birthplace Ireland

16. Informant Hospital records  
 Address Catonsville-28, Maryland

17. Burial Date thereof 1/7-46  
 (Burial, cremation, or removal. When?) (month) (day) (year)  
 Cemetery or crematory New Cathedral  
 Location City

18. Funeral director John R. Werning  
 Address 1242 Reed St., Annapolis Md - 27

19. 1/9 19 46 Harry Miller  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1946 at 9:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
February 3 1943 to January 3 1946  
 and that I last saw her alive on January 3 1946

Immediate cause of death Broncho pneumonia DURATION 2 1/2 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other \_\_\_\_\_Address Catonsville-28, Md. Date signed 1/4/46



RECEIVED  
JAN 10 1966  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

Reg. Dist. No. 00332 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 months, 6 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 4 months, 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore-17  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1614 Eutaw Place  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Evangeline Thompson

## 3.(b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife William M. Thompson

7. Birth date of deceased (mo., day, yr.) January 15, 1867 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 78 Months 11 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Stirling, Illinois  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Howard A. Munson

13. Birthplace Albany, New York

14. Maiden name Anna Eliza Roberts

15. Birthplace ?

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Bessie Date thereof 1/15/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Creek

Location Washington, D.C.

18. Funeral director John A. Miller & Son

Address 1900 Eutaw Place

19. 1-14 46 Harold Miller  
 (Date rec'd by registrar) (year) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 19 46 at 11:00 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 5 19 45 to January 11 19 46 and that I last saw him or her alive on January 11 19 46

Immediate cause of death Cerebral thrombosis DURATION 52 hrs.

Due to \_\_\_\_\_

Due to Generalized arteriosclerosis Indef.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Furk M. D. or other \_\_\_\_\_

Address Catonsville-28, Md. Date signed 1/11/46

RECEIVED  
JAN 15 1946  
BUREAU OF

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 57

00333

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

## 2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....  
(If outside city or town limits, write RURAL and give town)(d) Street No.....  
(If rural give location)(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

## 3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account  
No.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1946, at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide gas poisoning.

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... 1/13/46 at 8 P.M.

(b) Where did injury occur? Above address.

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work by Asphyxiation

(d) Means of injury Coal gas from heater.

23. Signature Benedict Skitarelic M.D.

Date signed 1-15-46

Medical Examiner.

FATHER

12. Name..... Samuel Tracey

13. Birthplace..... Balto. Co. Md.

MOTHER

14. Maiden Name..... Mary Gimm

15. Birthplace..... Balto. Co. Md.

16 (a) Informant..... Mrs. Wm. B. Ayers

(b) Address..... Cockeysville, Md.

17 (a) Burial (b) Date thereof Jan. 18, 1946  
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory..... Poplar Grove

Location..... Cockeysville, Md.

18 (a) Funeral director..... Landrum m. Berda

(b) Address..... Sparks, Md.

19 (a) Jan 15 1946 (b) Registrar  
(Date rec'd by registrar) William C. Nelson

Jan 16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please, write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

00334

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Owings Mills  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 37 years  
 Hospital, institution, or street address where death occurred:  
Garrison Road - 3  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Owings Mills  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Garrison Road  
 (If rural, give LOCATION)  
No  
 2.(a) if veteran, name war No

## 3. (a) FULL NAME

Annie Elizabeth Wessel Turnbaugh

## 3. (b) Social Security Number

None

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced W.

6.(b) Name of husband or wife Jacob Henry Turnbaugh

7. Birth date of deceased (mo., day, yr.) April 27 1880 8.(c) If alive, give age ..... years

8. AGE: Years 65 Months 8 Days 18 If less than one day ..... hrs. .... min.

9. Birthplace Owings Mills-Balto Co-Maryland  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business -

FATHER 12. Name Henry Wessel  
 13. Birthplace Germany

MOTHER 14. Maiden name Catherine Batts  
 15. Birthplace Atlantic Ocean

16. Informant Howard Lee Turnbaugh  
 Address Owings Mills Md

17. Burial Date thereof Jan 17 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pleasant Hill Cemetery  
 Location Owings Mills Md

18. Funeral director Wm Berryman & Sons  
 Address Reisterstown Md

19. 1-16- 19-46 Mary A. E. Line  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 19 46, at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-27-'38 19....., to 1-15 19 46  
 and that I last saw her alive on 1-7-'46 19.....

Immediate cause of death arteriosclerosis DURATION 2 1/2 yrs

Due to Diabetes 3 yrs

Due to .....

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide None Date of.....

Where did injury occur? .....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE D. D. Carley, M.D. M. D. or other  
 Address Reisterstown, Md Date signed 1-16-46

CERTIFICATE OF DEATH

RECEIVED  
JAN 19 1946  
BUREAU V R



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore CoCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

Dr. Sargent's SanatoriumHow long in hospital or institution? 2 years

## 3. (a) FULL NAME

Mabel Rachel Vickery

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County City of BaltimoreCity or town Earl Court Apts  
(If outside city or town limits, write RURAL and give nearest town)Street No. St. Paul & Preston Streets  
(If rural, give LOCATION)2. (a) If veteran, name war None

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife Single7. Birth date of deceased (mo., day, yr.) January-21-1871

6. (c) If alive, give age ..... years

8. AGE: Years 74 Months 11 Days 20 If less than one day  
..... hrs. .... min.9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation None11. Industry or business NoneFATHER 12. Name Edward M. Vickery13. Birthplace Baltimore, MdMOTHER 14. Maiden name Augusta Henderson15. Birthplace England16. Informant Mr. Stephen Vickery (brother)Address Earl Court Apts., St. Paul & Preston17. Burial Date thereof Jan-14-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon Park CemeteryLocation Baltimore, Maryland18. Funeral director Stewart & Mowen CompanyAddress 108 W. North Ave., City.19. 1-14 X6 W. D. or other  
(Date rec'd by registrar) 19. 1/12/46 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1946 at 9:45 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1946 to Jan 11 1946  
and that I last saw him alive on Jan 11 1946

Immediate cause of death

Coronary Occlusion  suddenDue to arterio-sclerosis  sub.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. D. or otherAddress W. D. or other Date signed 1/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0033844

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.How long in hospital or institution? 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 716 W. Fayette St.  
(If rural, give LOCATION)2.(a) If veteran, name war SAW ✓

## 3.(a) FULL NAME

AUGUST WARNECKE

## 3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Male</u>	<u>white</u>	<u>single</u>

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 16, 1867

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>1</u>	<u>5</u>	.....hrs. ....min.

9. Birthplace Germany  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name unknown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Clinical Records, Vets. Adm.Address Fort Howard, Md.17. Buried Date thereof 1/17/75  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Balto Md.Location Frederick Rd18. Funeral director E. Duane ToulsonAddress 2359 W. York Blvd19. 1-10-86 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 19 46 at 9:55P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 19 46 to January 8 19 46and that I last saw him alive on January 8 19 46Immediate cause of death Pneumonia, lobar, rt. lower lobeDURATION unknown

Due to

Due to

Other conditions Coronary Arteriosclerotic heart Disease; Psychosis with cerebral arteriosclerosis  
(Include any chronic conditions of 1 month or more duration)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A.M. BALTER, LT. COL. M.C. CLIN. DIR.  
M. D. or otherAddress Fort Howard, Md. Date signed 1-9-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

00337 33

## 1. PLACE OF DEATH:

County..... Baltimore Co.City or town..... Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 7 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... BaltimoreCity or town..... Reisterstown MD  
(If outside city or town limits, write RURAL and give nearest town)Street No. .... Sawyer & Butler Roads  
(If rural, give LOCATION)2.(a) If veteran, name war..... Spanish American

## 3. (a) FULL NAME

George W. Watts

## 3. (b) Social Security Number

4. Sex.....

Male

5. Color or race.....

White

6. (a) Single, married, widowed, or divorced.....

Divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... Sept. 1878

6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.

679. Birthplace..... Baltimore Md.  
(Town, county, and state)10. Usual occupation..... None - Veteran11. Industry or business..... Spanish American Gen.12. Name..... James Watts13. Birthplace..... Baltimore Md.14. Maiden name..... ?15. Birthplace..... ?16. Informant..... Mrs Elizabeth B. WestAddress..... Sawyer & Butler Roads17. Burial, cremation, removal, which?..... Burial Date thereof..... 1-10-1946  
(month) (day) (year)Cemetery or crematorium..... London Park Baltimore NationalLocation..... Baltimore Md.18. Funeral director..... Flynn & FlynnAddress..... 1476 Light St.19. 1-9 1946..... Accepted  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1-7-46 19..... at 5:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-46 to 1-7-46 and that I last saw him alive on 1-6-46Immediate cause of death..... Pulmonary Tuberculosis

## DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... James L. Saffel M. D. or otherAddress..... Reisterstown Md. Date signed..... 1-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and intelligibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bd*

## CERTIFICATE OF DEATH

Reg. Dist. No. *43*

## 1. PLACE OF DEATH:

County *Baltimore*City or town *Raspeburg Baltimore 6 Md*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Lucy C Weaver*

## 3. (b) Social Security Number

4. Sex

*Female*

5. Color or race

*White*

6. (a) Single, married, widowed, or divorced

*Widow*

6. (b) Name of husband or wife

*William Weaver*

7. Birth date of

deceased (mo., day, yr.)

*July 21 1865*

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

*80**6**1*

hrs.

min.

9. Birthplace

*Baltimore Md*

(Town, county, and state)

10. Usual occupation

*At Home*

11. Industry or business

FATHER

12. Name

*Edward Myers*

13. Birthplace

*Germany*

MOTHER

14. Maiden name

*Mary E Stahl*

15. Birthplace

*Unknown*

16. Informant

*Mrs Carl Rauck*

Address

*5510 Kenwood Ave*

17.

*Burial*

(Burial, cremation, or removal. Which?)

Date thereof

*1/25/46*

(month) (day) (year)

Cemetery or crematory

*Loudon Park*

Location

*Frederick Road*

18. Funeral director

*Lassahn Funeral Home*

Address

*7401 Belair Road*

19.

*Jan 24. 46*  
(Date rec'd by registrar)*46**Mrs G. L. Reiser*  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Baltimore*

City or town

*Raspeburg*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

*5510 Kenwood Ave*

(If rural, give LOCATION)

2. (c) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*Jan 22 1946**8.10* at *A*

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Dec 28**1945*to *Jan 22**1946*

and that I last saw him/her alive on

*Jan 21**1946*

Immediate cause of death

*Acute pulmonary edema*

DURATION

*2 days*

Due to

*Chr myocardial disease**2 yrs*

Due to

Other conditions

*Atherosclerosis*

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Carl E. Hackett MD*

M. D. or other

Address

*4116 Northern Parkway*

Date signed

*1/23/46*

Dr Hichew

North Perry & Belair Rd





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

00340 P

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Owings Mills  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 32 days  
 Hospital, institution, or street address where death occurred:  
Rosewood State Training School  
 How long in hospital or institution? 32 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Owings Mills  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rosewood State Training School  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Wayne Leonard Weeks

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 5/9/40  
 8. AGE: Years 5 Months 8 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bastian, Va.  
 (Town, county, and state)  
 10. Usual occupation Inmate  
 11. Industry or business \_\_\_\_\_

FATHER 12. Name Milton Aldridge Weeks  
 13. Birthplace Warrenton Va.  
 MOTHER 14. Maiden name Ruby Byrd  
 15. Birthplace Rocky Gap, Va.

16. Informant Institutional Records  
 Address Rosewood St. Trng. School  
 17. Burial Date thereof Jan. 21-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Marbury Baptist Cem  
 Location Marbury Md  
Stunth + Ryon

18. Funeral director Waldorf Mch  
 Address \_\_\_\_\_

19. Jan 19 1946 A. W. Hedwich  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 1946 at 9:20 A.M.  
 21. I CERTIFY that death occurred on the date above dated; that I attended deceased from December 17, 1945 to January 18, 1946  
 and that I last saw him alive on January 18, 1946

Immediate cause of death Broncho-pneumonia DURATION 5 da.

Due to Acute bronchitis 9 da.

Due to \_\_\_\_\_

Other conditions Congenital muscular atonia  
(myotonia congenita) 5 yr +  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. H. Butler M. D. or other  
 Address Owings Mills, Md Date signed 1/18/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 yrs  
 Hospital, institution, or street address where death occurred:  
Masonic Home, Cockeysville Md  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County .....

City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 221 S. Clinton St  
 (If rural, give LOCATION) ✓

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Mrs. Elizabeth J. Weigert

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Anthony J. Weigert

7. Birth date of deceased (mo., day, yr.) Dec. 3 - 1858 6.(c) If alive, give age .....

8. AGE:	Years	Months	Days	If less than one day
	<u>87</u>	<u>1</u>	<u>23</u>	hrs. min.

9. Birthplace Baltimore Md  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

FATHER 12. Name Joseph Guthrie

13. Birthplace Calais Maine

MOTHER 14. Maiden name Ann Marshall

15. Birthplace Baltimore Md

16. Informant Laura M. Schroeder

Address Masonic Home, Cockeysville Md

17. Burial Date thereof 1-29-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Deplawn

Location Eastern Ave. Rd. beyond City

18. Funeral director Dr. L. Byrd J. Limb

Address 1512 Hollins St.

19. Jan. 26 19 46 L.M. Schroeder  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 19 46 at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 43 to Jan 26 19 46

and that I last saw him alive on Jan 26 19 46

Immediate cause of death

Cardiac Decompensation DURATION 3 weeks

Due to

Generalized Arteriosclerosis 10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Solomon Sherman M.D.  
 M. D. or other

Address 2424 Canton Pl. Date signed 1/26/46

RECEIVED

JAN 29 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

00342

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Balto.City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Edmondson Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4 Northland Rd.  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3.(a) FULL NAME

HELEN WEIKEL

## 3.(b) Social Security Number

nohe

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widow

B.(b) Name of husband or wife John Weikel

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1857

## 8. AGE:

Years

Months

Days

If less than one day

88

11

11

hrs. min.

9. Birthplace Erie, Pa.

(Town, county, and state)

10. Usual occupation None

## 11. Industry or business

12. Name William Schaaf13. Birthplace Germany14. Maiden name Unknown15. Birthplace IT16. Informant Mr. John P. WeikelAddress 4 Northland Rd., Woodlawn, Md.17. Burial Date thereof 1/26/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WoodlawnLocation Woodlawn, Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. Jan 26 19 46  
(Date rec'd by registrar)Alfred H. Reich  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 19 46 at 8 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 46 to Jan 23 19 46 and that I last saw him alive on Jan 23 19 46

Immediate cause of death

Pneumonia

DURATION

3 days

Due to

Due to

Other conditions

Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alfred H. Reich M. D. or otherAddress Catonsville Date signed 1-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

00343

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

Hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

10

19

and that I last saw h. alive on

19

Immediate cause of death

DURATION

Due to

Dun to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 1/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

## CERTIFICATE OF DEATH

Reg. Dist. No. 00344 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs., 10 mos., 5 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 2 yrs., 10 mos., 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1924 North Monroe Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Edwin S. Whiteside

## 3.(b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife

-

8.(c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.)

October 2., 1879

## 8. AGE:

Years

Months

Days

If less than one day

66316

hrs.

min.

## 9. Birthplace

Maryland

(Town, county, and state)

## 10. Usual occupation

Factory worker

## 11. Industry or business

Factory

## FATHER

## 12. Name

Samuel Whiteside

## 13. Birthplace

Ireland

## MOTHER

## 14. Maiden name

Sara Crist

## 15. Birthplace

Maryland

## 16. Informant

Hospital records

## Address

Catonsville-28, Md.

## 17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

1/21/46

(month) (day) (year)

## Cemetery or crematory

Loudon Park Cem.

## Location

Balto., Md.

## 18. Funeral director

WM. J. TICKNER & SONS

## Address

Balto., Md.

## 19.

Date rec'd by registrar

19

46A. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1946 11:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 13 1943 to January 18 1946and that I last saw him alive on January 18 1946

Immediate cause of death

Chronic pulmonary tuberculosis  
with cavitation

DURATION

Indef.

Due to

Chronic hypertensive cardio-  
vascular-renal disease

"

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Isidoro Turk  
Isidoro Turk, M.D.

M. D. or other

Address Catonsville-28, Md. Date signed 1/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for changing  
day of birth shown on  
Birth D135 8/9/51 Jn

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1064

00345

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

105 Newburg Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County DachCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 105 Newburg Ave  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Charles E Wilson

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mildred H.

7. Birth date of

deceased (mo., day, yr.)

July 17, 1878

8. AGE:

Years

Months

Days

If less than one day

67 5 22

hrs.

min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

John S Wilson

12. Name

John S Wilson

13. Birthplace

MD

14. Maiden name

Rebecca Minnich

15. Birthplace

MD

16. Informant

Mrs Chas E Wilson

Address

105 Newburg Ave 46

17. Burial

Funeral Home

(Burial, cremation, or removal, which?)

Date thereof 1-11-46  
(month) (day) (year)

Cemetery or crematory

St. Mary's

Location

St. Mary's

18. Funeral director

George A. Farley

Address

Tulsa & Jay St19. 1-11-4619 46 Harry H. Miller  
(Date rec'd by registrar) Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 8th 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1, 1945 to Jan 8, 1946and that I last saw him alive on Jan 8, 1946

Immediate cause of death

Postencephalicparaneuronal syndromeDue to Postencephalicparaneuronal syndrome

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed 1-11-46



*In Howell*

RECEIVED  
JAN 14 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

00346

9

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 years, 11 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 6 years, 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore (Curtis Bay)  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1626 Hazel Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Carrie ~~Wolfe~~ (Wolfer or Witkowski)

## 3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female

white

single

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 14 - 1890

8. AGE:

Years

Months

Days

If less than one day

5580

hrs.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual occupation

Factory worker

11. Industry or business

Retired

FATHER

12. Name

John Witkowski

13. Birthplace

Poland

MOTHER

14. Maiden name

Mary Kryszkowski

15. Birthplace

Poland

16. Informant

Hospital records

Address

Catonsville-28, Maryland

17.

(Burial, cremation, or removal, which?)

Date thereof

1/17/46  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by Registrar)

19.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1946, at 6:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 3 1940, to January 14 1946and that I last saw her alive on January 14 1946

Immediate cause of death

Coronary thrombosis

DURATION

13 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Isadora Tuerk, M.D.

M. D. or other

Address Catonsville-28, Md. Date signed 1/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-2)

00347

P 30

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville 28  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs. 6mo. 1 day

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 5yrs. 6mo 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Julyana Wojashuski Wojciechowski (ORLOWSKI)

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife. ( Unknown ) Wojashuski

8. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 14 or 15, 1870

8. AGE: Years Months Days if less than one day

75 7 5 ..... hrs. .... min.9. Birthplace Poland  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Crwanka13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Hospital RecordsAddress Catonsville 2817. Burial Date thereof Jan 23/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy RosaryLocation Baltimore18. Funeral director Frederick W. OzajewskiAddress 1930 Eastern Ave.19. 1/21 19 46 Conrad H. ...  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 20, 19 46, at 2:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 19 40, to January 20, 19 46.and that I last saw her alive on January 20, 19 46.Immediate cause of death Chronic Myocarditis

DURATION

Indef.Due to Arteriosclerotic cardiovascular diseaseIndef.

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

..... Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Myrick W. Pullen, Jr.

M. D. or other

Address Catonsville 28, Md. Date signed 1/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH: Baltimore  
 County Raspeburg  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Raspeburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 113 Belmar Ave  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

3. (a) FULL NAME Geo H Young Sr

3. (b) Social Security Number  
705-09-8018

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Christina M Young

7. Birth date of deceased (mo., day, yr.) Dec 27 1883 6. (c) If alive, give age years

8. AGE: Years 62 Months 0 Days 15 If less than one day  
 hrs. min.

9. Birthplace Baltimore Md  
 (Town, county, and state)

10. Usual occupation Machinist

11. Industry or business

12. Name Geo C Young

13. Birthplace Baltimore

14. Maiden name Unknown

15. Birthplace if

16. Informant Miss Kathryn Young  
 Address 113 Belmar Ave

17. Burial 1/14/46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Holy Redeemer Cemetery  
Belair Road  
 Location

18. Funeral director Lassahn Funeral Home  
 Address 7401 Belair Road

19. Jan 11 - 19 46 Mrs A. L. Reifsnider  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

Jan 11 1946 5.50 AM

20. DATE OF DEATH 19 at M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 - 19 46 to Jan 11 19 46  
 and that I last saw him alive on Jan 11 19 46

Immediate cause of death

Coronary Thrombosis  
Cerebral Hemorrhage  
Arteriosclerosis  
 Other conditions

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Michael J. Reifsnider M. D. or other  
 Address 5407 Belair Rd Date signed 1-11-46

RECEIVED  
JAN 16 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs., 6 mos., 13 days  
 Hospital, institution, or street address where death occurred Mt. Wilson Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution? 2 yrs., 6 mos., 13 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4602 Harford Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Edward Zipprian

## 3.(b) Social Security Number

# Unknown

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Elizabeth Zipprian  
 6.(c) If alive, give age 37 years  
 7. Birth date of deceased (mo., day, yr.) March 3, 1911  
 8. AGE: Years 34 Months 10 Days 26 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ellicott City, Maryland  
 (Town, county, and state)  
 10. Usual occupation Printer  
 11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Edward Zipprian  
 13. Birthplace Maryland  
 14. Maiden name Mary Ellen Wilson  
 15. Birthplace Virginia

16. Informant Edward Zipprian  
 Address 4602 Harford Rd., Balto., Md.

17. Burial Date thereof Feb. 1, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Meadow Ridge Memorial  
 Location Wash. Blvd., Balto. Co., Maryland

18. Funeral director Leonard J. Ruck  
 Address 5305 Harford Rd., Balto., Md.

19. 1/29/46 19 Earl T. Webster  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1946 at 5:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16, 1943 to Jan. 29, 1946 and that I last saw him alive on January 29, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 9 yrs.

Due to Tubercle Bacilli

Due to \_\_\_\_\_

Other conditions Tuberculous Enteritis 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations No operation Date of op. \_\_\_\_\_

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stewart S. Shaffer M.D. M.D. or other \_\_\_\_\_

Address Mt. Wilson, Md. Date signed 1/29/46



RECEIVED

FEB 1 1946

BUREAU V. S.